08-02782	
Rryan An	toine Adams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ype or a mile in	Didox indendie nik.	Ellouio / ul oo	p.100 / 0
State of Maryla	nd / Department of He	ealth and Menta	Hygiene

)	Constant Constant	í i	2	P	2	5	N
	U	30	U		E.m.	U	$\cup$

Physician/	For State eqistrar Decedent's Name (First, Middle,Last)	ficate of Death	Reg. No. 2. Date of Death Month Day	3. Time of Death
ical Examiner	Bryan Antoine Adams, Jr.  a. Facility Name (if not institution, give street and number)  Howard County General Hospital	4b. City, Town, or Location of Columbia	April 9, 2008  Death 4	c. County of Death
Tulleral	. Social Security Number 6. Sex 7. Age (In yrs. last 213–17–5588 1 X M 2 F 20	birthday) If Under 1 Year If Under		VDD/YYYY) 9. Birthplace (State or
ow any	MD Howard Colum  0e. Street and Number  5532 Suffield Court  1. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	10f. Zip Code 21044  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	us n? (Specify Yes or No-	14. Race - American Indian, Black, White, etc. African
n 72 hours afte	Elementary/Secondary (0-12) College (1-4 or 5+) 12th  17. Father's Name (First, Middle, Last) Bryan A. Adams		From Name (First, Middle, Maide ey Managana	
Pages 1 an nent of Hear tr	1 X Burial 2 Cremation 3 Removal from State	5532 Suffield Court Co ace of Disposition (Name of cemetery, ematory or other place)	Date 2004 4/17/2008 Wylie Funeral H	Location - City or Town, State  Elkridge, MD  Home P.A. of Balto. Co.
/Medical yaminer	22a. Part I. Enter the disease, or complications that caused the death. It failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause First Underly is Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  Multiple Gunshot Wound Due to (or as a consequence of)  b. Due to (or as a consequence of)  c. Due to (or as a consequence of)  d.	Do not enter the mode of dying, such as ca	rdiac or respiratory arrest, s	hock, or heart Approximate Inter Between Onset a Death
box 60/ death certific he attending p d for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  23c. If yes, outcome of pregnant in the pregnant at time of dealing unknown  2 Unknown  2 Contributing to death but not reconditions	2 Fetal death 3 Ectopic th 5 Other (Specify) sulting in the underlying cause given in Pa	rt I. 23e. Did tobaα 1  Yes 2 24a. Was an autopsy performed 1 ✓ Yes 2	23d. Date of delivery  Month Day Year  Co use contribute to the cause of death?  No 3 Probably 4 Unknow  24b. Were autopsy findings availarior to completion of cause death?  1? Yes 2 No
DIVISION Of VITAI  To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director.  Medical Certification: To Be 6	27. Manner of Death  1 Natural 5 Pending Apr 9, 2008  2 Accident Investigation	26.Place of Death  ER/Outpatient 3 DOA Other,4  28b. Time of Injury  1130 hrs 28c. Injury at Work  1 Yes 2   me, farm, street, factory, office building, et  te, death occurred at the time, date and pla  id/or investigation, in my opinion, death oc  29c. License number  O.C.M.E.	Nursing Home 5 Res  28d. Describe how Subject shot  28f. Location (Street or Town, State Twin Rivers Road ace, and due to the cause(s) accurred at the time, date and	et and Number or Rural Route Number, of South of Lynx Lane, Columbia, MD
5	30. Na e and address of person who co pleted cause of death (Item Melissa Brassell, MD Assistant Medical Examin 31. Date filed (1637) Day, Year) 2008 Registrar's Signature.		e, MD 21201	

To the Hospi within 24 hou To the Funer To the Funer completely fill to th

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scal Victor Substitute
31. Date filed (Month, Day Year)

12. Registrar's Signature

Swetz 204 Millerville, My 21108

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 145 M /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PALTIMONS\_ If Under 1 Year | If Under 24 Hrs. 10A 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 12M 2DF Months Hours Min. Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [Pres 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 1No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO.NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College/(1-4or 5+) Elementary/Secondary (0-12) tee L 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be drew ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baeto. -niece 514 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State oudon 4 ☐ Donation 2 5 ☐ Other (Specify) ar 21. Signature A Funeral Service Licens 22. Name and Address of Facility Fred HILTON 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocky opnieart failure. List only one cause on each line. Bacto. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** disease or condition resulting in death) 14 W5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be execut and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 √ nknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ANo cancer 24a. Was an After this certificate has autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 A Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) Baltinory, Maryland 3 North 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

7 2008

gistrar's Signature

			1 - State Registrar			,	Ce	rtificat	e of	Death		iornai i iy	Reg. N	io.	-	- Contra	
	Dhari		1. Decedent's Name	(First, Middl	e, Last)							2. Date of De	ath		Т	3. Time of	f Death
	Physic /Med		Doane A	. Brooks	3							Month Apri	1 2	13 200	8	5 <b>:</b> 55	a.M
	Exami		4a. Facility Name (If		-	umber)		4b. City,	Town, o	Location	of Death		4	c. County of De	ath		
4			404 Wist						en Bu					Anne An	unde	1	
	Funeral		5. Social Security Nu	mber	6. Sex 1 X M 2 □ F		. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Yea	r) 9. B	irthplac Cou <i>ntr</i> y	ce (State o	or Foreign
	Director		214-62-1742 Usual Residence of I	Decedent		5.2	113.					6-25-1	.955			MD	
	yland		10a. State	10b. County		10c. C	ity, Town or Lo	cation	_						10d	. Inside Ci	ity Limits
	a-fs	cto	MD	Anne	Arundel		Glen Bun	nie								1 ☐ Yes	2 XNo
	or 28	Director	10e. Street and Num					10f. Zip	Code		,		10g. C	Citizen of What C	Country	1?	
	ath w	ra	404 Wist	ful Vist	a Court			2	21061			ļ	J	JSA			
	er de	nue.	11. Marital Status	7.7	Armed F	edent Ever in U orces?	J.S. 13.	Was Deced	ient of H	ispanic Or ın, Mexicai	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Am Black, Wh			
36	ours after death with the Marylan al", or Items 23a or 28a-f show Evanium Lust be modfled at	by Funeral	1 ☐ Never Marrie 3 ☐ Widowed 4		ied 1 ∏Yes If Yes, G Year or I			1∐Yes 2		Specify:				Specify: A			rican
21215-0036				15. Decedeni	t's Education		16a. Dece	dent's Usua	al Occup	ation			16h	Kind of Busines			
215	hin 7 e. an "n	ompleted	(Specifical Elementary/Second	·	St grade completed,	1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring mos I)	t of worki	ng				,	
21	ygien ygien er th	ပ္ပြ			- College (	1 401 5+7	Fork	ift Te	echic:	ian			Fa	astem Lif	Et T	ruck	
Maryland	be fill d oth even	Be	17. Father's Name (F		Last)							(First, Middle,	Maide	n Surname)			
2	ould Mer narke	은	Wilbur Broo								Burre						
Ma	d 2 sh th an 7 is r traur		19a. Informant's Nar Evette Y. We											or Town, State,	Zip Co	ode)	
a,	1 an Heal tem 2	-	20a. Method of Dispo		NIIC	20h	Place of Dispo	istful	<u>Vist</u>	<u>a Cour</u>		en Burnie	<u>, M</u>	D 21061 Location - City o	- T	01.1	
OL.	ages ent of nt: If ii		1X□ Burial 2 □	Cremation	3 Removal from		Place of Dispo cemetery, cren										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any injury or other traumatic event, tre Medical once."	_	4 Donation 5				lar Hill				-19-0		Da.	ltimore, l ne P.A. of	rary	'Land	-
Ä	Depa Impo any I		TAGO.	do	0 11/0	X1110	920	0 Libe	ertv I	Road. 1	Randa.	llstown,	$MD_2$	21133	. Dit	IW. C	D.
			23a. Part 1. Enter the	disease, or	complications that only one cause on e	caused the deat									A	pproximate	e
m	Physician		Immediate Cause (F		4										In O	terval Bet nset and D	ween Death
	/Medical		resulting in death)	(1)	Due to	(or as a consec	quence of):	ma	-								
	Examiner	_	Sequentially list cond	litions		enal fa	ilvre										
	De Wis	ine	Sequentially list cond if any, leading to immo cause. Enter Underly Cause (Disease or in	ring -	Due to	(cras a consec	uenea offi										
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) La	1	c	(or as a conseq	mence of)		_				_				
68760,	e be e siciar	Sal				(	,======================================										
68	tificat ng ph) as th	Medical			u.												
Вох	th cer endir		IF FEMALE: 23b. Was decedent p			tcome of pregna		le						23d. Date of de	elivery		
-	The law requires that the death orate has been signed by the attencoage 2 should be detached for us	Physician	in the past 12 m 1 ☐ Yes 2 ☐ I			nant at time of		Ectopic pro Other (spe						Month	Da	y Y	⁄ear
P.0	ires that the de signed by the a I be detached f	Phy	9 Unknown								_						
S,	signe signe		Part II. Other signific	ant conditio	ns contributing to de	eath but not res	ulting in the un	derlying ca	use give	n in Part I.				use contribute t			
Records,	w requir been s should	Completed by					+					1 🗆 Yo	es 2	No 3 1 P	robabl	y 4 🗆 U	inknown
Rec	has ge 2 s	ם										24a. Was a autops	sy _	24b. Were a prior to	compl	findings a	available ause of
a	ician: The certificate h ector, page		05.111									perform 1 □ Yes		death?		□No	
Vital		o Be	25. Was case referred examiner?  1 ☐ Yes 2 ☑ No.		Hospital:				Othe			(Check only on					
of		1 - 4	27. Mann f Death		28a. Date	Inpatient 2 🗍 of Injury	28b. Time of		<u> </u>	4 LI NU		ne 5 M Reside 8d. Describe ho		6 ☐ Other (Spe	ecify)		
ion	Attending ir death. ector: After by the fune	atio	1 Matural 2 ☐ Accident	5 Pending investigation		th, Day, Year)	Injury	М	lc. Injury Work? 1 □ Y	es 2∐N		ou. Describe in	ow anja	ry occurred			
Division	r Atte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be ned 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location (Si	treet a	nd Number or R	u <i>ral R</i> o	oute Numb	ber,
Ö	italo Irsaft ralDi	Cer		/								City or Towi		,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ical	29a. Certifier 1 (Check only 2	Certifying     Medical E	Physician: To the xaminer: On the b	best of my kno asis of examina	wledge, death	occurred a	t the tim	e, date an	d place, a	and due to the c	ause(s	s) and manner a	s state	ed.	
	thin 2 the mple	Medical	one) 29b. Signature and titl		and man	ner stated.					an occurre	7					
	5 × 5 8		290. Signature and titl	e or certifier	1			29c.	License		In	2	9d. Da	ate signed (Mont			_
	10	-	20. Nome and address	Mu	em, M	0			1)6	602	19		`	1-15	-	200	8
	50		30. Name and address	s of person w		e or death (Item	1 23a) (Type, P	rint)	~ \ /!	_	Tarin	Λ.	10	7 1 2m 1	1		
	Sta	te	31. Date filed (Month,			egistrar's Signa	ture	~ ( N	1 1 V	,	· UW J	m, 10	1()_	9 190	Γ		
	Registr	ar -	ДРР	1 7 2	08	L	1	00 -									
DHN	MH 17 Rev 1/20	001	711-11	TIEC	108 Sex	NO JON	19004										
							ORIGI	NAL									

2008 | 2505

April 1, 2008 The second processor of the second proce		eau	1- F	or State				/ Depart	ficate o	f Deat	h			Reç	g. No.		3. Time of	Death
Mark Declan Beauchamp Howard County General Hospital  Full County	Thyeir	rian		Decedent's Name (Fi	irst, Middle,	Last)								Annth	Day	Year		
Tar Pacify Name of Pacific Countrible  Cou				Mark I	Declar	n Beau	champ	)						pril 13, 20		County of Deat	h	
Howard County General Hospital  Tournel Working County (Fig. 1)  See Seat Seath Number   10   10   10   10   10   10   10   1			4a	Facility Name (if no	t institution	give street	and numbe	r)				cation of [	Death		1			
Security Princetors of Decisions   1.5 cours   1.5 cou				Howard County	y Genera	al Hospita	1			Colur	nbia			- 1 - 1 Dist			rthplace (St	ate or
Section   Control   Cont	F	-1	5.				7. A	ige (în yrs. las	it birthday)		_		_			Leore	lan	
TOTAL PRESENTING OF PROMISED TO THE STATE OF			- 1			1 X 1 2	T <sub>E</sub>	4	9 Y		ns Days	Hours	IVIII I	Dec.	11,	958 0	ountry) TI	1
To Size and Number   10 / New December   10 /	Directo	"	1-			1 2 W 2	'										104 Incid	lo City Limi
Shepherdstown   Top, Cirizen of What Contrays   Top, Cirizen	as a							10c. City, T	own or Loc	ation								
Section   The content of White Country   Total Age Content   Tot	wan					rcon			Sher	herds	stown							ss zi
Security	land f sho	3	5 LW	· · ·		LSOII								10	0g. Citi:	zen of What Co	untry?	
Security	Mary 28a-	da da	10								25443			1		U.S.A.		
Security	the l		5	262 Byre	Lane				113 1	Man Docos	lant of Hisr	anic Origi	n? (Spec	ify Yes or No	)-	14. Race - Ame	erican India	, Black,
Security	with ms 2.	pe n	1		0 1	Α.	/as Decede rmed Force	ent Ever in U.S es?	5.	f Yes, spec	ify Cuban,	Mexican,	Puerto Ri	can, etc.)	l	White, etc.		
Security	leath r ite	unst	Š   1	X Never Married		1	Yes	2 X No	4.0	Vas	o <b>X</b> No	specify:				Specify: W	hite	
21. Signayer of Syneral Services Licensee   Children's Ave.   Baltimore, MD 21224   Soft Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   Reproduction	fler (		-13										ind of wor	k done	16b.	Kind of Busines	s/Industry	
21. Signayer of Syneral Services Licensee   Children's Ave.   Baltimore, MD 21224   Soft Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   Reproduction	ours a	am:	-			cify only high	est grade		during	most of w	orking life.	DO NOT	use retired	<b>d</b> )	1			
21. Signayer of Syneral Service Licensee   Chariffest Statem Ave. Baltimore, MD 21224   Solar mind   Solar	72 hc	E .	ᆲ	Elementary/Second	dary (0-12)	C		or 5+)		Mana	cor				A	utomoti	ve	
21. Signayer of Syneral Service Licensee   Chariffest Statem Ave. Baltimore, MD 21224   Solar mind   Solar	thair thair	edic.	림				4		L	Maria	Jer	19 Mother's	s Name (f	First Middle.				
21. Signalure of Suneral Services Licensee   Chariffeet St. Zeller Ave. Baltimore, MD 21224   Sold Part Little disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feeting in death late the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feeting in death late the disease, or condition reculting in death. Late only one cause on each line. In the conditions, and in the condition reculting in death late or condition reculting in death). Late   Due to (or as a consequence of):    Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death Late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition	ed wi	he N	٦١ق	7. Father's Name (Fi	irst, Middle	Last)	_				- 1	Mar	rilvn	Clair	re S	andberg	7	
21. Signayre of Symeal Serging Lensee   1. Signayre   1. Signayre of Symeal Serging Lensee   1. Signayre Sympathy Lensee   1. Sign	ked		e l	Lee Roy	Beauc	champ,	Jr.		T =	tit Autologi	(Ct	1-JLLI	ber or Ru	ral Route Nu	mber. (	City or Town, St	ate, Zip Coo	ie)
Sicial Part   Electron   Source   Sou	Men Men	20		9a. Informant's Nam	ne/Relations	hip (Type, P	rint )		19b. Ma	alling Addre	ss (Stree	TATO TATE	377	lacrame	ent <i>c</i>	CA S	5822	
21. Signalary of Spanners Services   Lensese   1. Signalary of Spanners   1. S	2 sho 2 sho 1 and 27 is	mati		Marilyn C	C. Bea	aucham	p (Mo	ther)					-		20c	Location - City	or Town, S	tate
21. Signayre of Symeal Serging Lensee   1. Signayre   1. Signayre of Symeal Serging Lensee   1. Signayre Sympathy Lensee   1. Sign	and and lealth	tran		0a. Method of Dispo	osition				Place of Dis	position (No.	ce)							
21. Signalure of Suneral Services Licensee   Chariffeet St. Zeller Ave. Baltimore, MD 21224   Sold Part Little disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feeting in death late the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feeting in death late the disease, or condition reculting in death. Late only one cause on each line. In the conditions, and in the condition reculting in death late or condition reculting in death). Late   Due to (or as a consequence of):    Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death) Late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death Late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition reculting in death late   Due to (or as a consequence of):   Very condition	Ore ges 1 t of F	ther					emoval fron	St	Mar	y's C	emete	ry	4-23	3-2008				
Sician   S	Fant Then	9		4 Donation 5	Other S	pecify:			12	22 Name a	nd Addres	of Facility	ller	& Son	, I	uneral	Home,	Inc.
Sician   S	Sall ermit epar	i i	- 1	1-46	15%	-		_		6224	East	ern	Ave.	Balt:	imoı	ce, MD	21224	
The proof of the p			aminer	if any, leading to imicause. Enter Under (Disease or injury the	mediate rlying Caus- nat initiated	e c												
The late of the la		ransit	I	events resulting in a	2000	d.					100							
The late of the la	exec	an ar al - t	ica	X UNPENDED		AA	MENDED2	3a,27 pe	r ME g8	378 5/1	L/08 an	nh						
The late of the la	, e be	bun	<u>e</u>			t t												Yea
The late of the la	876 iifical	ng ph	칠	23b. Was decedent i	pregnant in	the 1	Live b	irth	2		,	Ectop	ic pregna	incy		Month	Duj	
Natural S Pending Investigation 2 Accident Suicide 3 Suicide 6 Could not be determined (Specify)  2 Accident Suicide 6 Could not be determined (Specify)  2 Suicide 7 Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Suicide 7 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Suicide 8 Could not be determined (Specify)  2 Suicide 9 Could not be determined (Specify)  2 Suicide 9 Could not be determined (Specify)  2 Suicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Suicide 9 Could not be determined (Specify)  2 Suicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  2 Suicide 2 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  2 Suicide 1 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  2 Suicide 2 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  2 Suicide 2 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  2 Suicide 2 Certifier 2 Certifie	h cert	use	icia			4			death 5	Other (	(Specify)							
The standard of the standard o	Bo	the at	nys						t reculting is	the under	lving cause	e given in l	Part I.					
The property of the part of th	O #	d by		Part II. Other signi	ificant con	ditions cor	itributing to	geath but not	t resulting in	T (TIC GITGO)	.,9	J		1 🗌	Yes	2 No 3	Probably	4 🗸 Unki
Natural S Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Town, State)    Suicide   Accident   Suicide   Could not be determined   (Specify)	o. a a a a a a a a a a a a a a a a a a a	signe be de	d b											24a, W	as an	24b. We	ere autopsy	findings av
The standard of the standard o	ds	peen	ete											aı	utopsy	pri	or to comple	etion of cau
The property of the part of th	law law	has l	ldu													-		2
The property of the part of th	a ₽	pag	Ç								26.Pla	ce of Dea	th (Check	only one)				
The property of the part of th	is.	certif	a)		rred to med		oital:	Innationt 2	✓ FR/Out	patient 3	DOA	Other <sub>4</sub>	Nursi	ng Home 5	Re	sidence 6	Other:	
The standard of the standard o	hysic Si	this al dir	0	1 🗸 Yes								njury at We	ork?	28d. Descr	ribe hov	v injury occurre	d	
The standard of the standard o	of Fig.	After			r		(Monti	h, Dey,Year)				Yes 2	No	1				
29b. Signature of certifier  O.C.M.E. April 14, 2008  30. Name and address of person who completed cause of death (Item 23a)  111 Page Street Baltimore MD 21201			atio						i i a sa a dam	m atroot fo	actory offic	e building	etc.	28f. Locati	ion (Str	eet and Numbe	r or Rural R	oute Numb
29b. Signature of certifier  O.C.M.E. April 14, 2008  30. Name and address of person who completed cause of death (Item 23a)  111 Page Street Baltimore MD 21201	ViSI or At	irect in by	] <u>:</u>						t nome, ran	II, Street, 16	actory, one	o Bonanig		or Tov	wn, Stat	e)		
29b. Signatury and title of certified  O.C.M.E. April 14, 2008  30. Name and address of person who completed cause of death (Item 23a)  111 Page Street Baltimore MD 21201	ital o	Iled i	er		d	etermined	(Specify,	)						<u> </u>		a) and manner	as stated	
29b. Signature of certifier  O.C.M.E. April 14, 2008  O.C.M.E. April 14, 2008  30. Name and address of person who completed cause of death (Item 23a)	dsa	Pune ely fi		29a. Certifier	Certifyin	g Physician	: To the be	est of my know	ledge, deat	h occurred	at the time	, date and	place, ar	nd due to the	date an	d place, and du	ue to the car	ıse(s)
29b. Signatury and title of certified  O.C.M.E. April 14, 2008  30. Name and address of person who completed cause of death (Item 23a)  111 Page Street Baltimore MD 21201	= 4	the I	ica	one) 2	Medical	Examiner:0	n the basis	of examination	on and/or in	vestigation	, iii iiiy opii	non, doda		action amor				Day, Yearl
30. Narrie and address of person who completed cause of death (Item 23a)  114 Pens Street Baltimore MD 21201	the Ho	To	Sec			اع	A MAINTE	<u> </u>			29c. Lic	ense numb	рег		- 13	29d. Date signe	su (Month, t	-uy, 1 cai/
30. Name and address of person who completed cause of death (Item 23a)	To the Ho within 24		1 =	1//	/	1	1/1	W			0.	C.M.E.			}	April 14, 20	NA	
	To the He within 24			111111111111111111111111111111111111111	//										1.			
WALL BANGS OF SOME WILL ACCIDENT WIND CONTROL CAMBINOTO	To the Ho within 24	_/		Mu	n 12	rasse	1,	una as de ath (	Item 23a)									

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 45 am **Physician** APCI Bury 2008 Virginia Tee 4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosed SQUATE Hospital Center Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2 F 80 Cumberland, Maryland 12,1928 April Director 216-22-5385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No r 28a-f sh notified Directo Dundalk Maryland Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ann of Health and Mental Hygiene. ann of Health and Mental Hygiene. and It flem 27 is marked other than "natural", or Items 23a or it in yor other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner. USA 21222 7855 St. Claire Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u> Housewife</u> Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Catherine Hunt Francis E. Blank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John R. Coleman son 114 Kinship Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Apri $\Gamma^{atg}$ 7. 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Clostridium Colitis Immediate Cause (Final Difficile Physician disease or condition /Medical resulting in death) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 No death? 2 No 1∏ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6 (33 MD 4/16/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DR Farid Ahmed
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

9000 Franklin Square DR Baltimore Maryland 2/237

08-02892
Shirley Burton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nirley Burton		State of Maryland / Department of Certificate of Ce	of Health and Mental Hy of Death	ygiene Reg. N	200	18 1250
Physicial edical Examin	n/ T	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da April 13, 2008	y Year	3. Time of Death 0829 hrs
		a. Facility Name (if not institution, give street and number)  Harbor Hospital	4b. City, Town, or Location of Death Baltimore	7,1011	4c. County of Death	7
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	<b>-</b>	M/DD/YYYY) 9, Bir Foreig Co	
Aaryland 28a-f show any 1 at once.	Ī	Jsual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Loc  N A 10c. Street and Number	ation  att more  10f. Zip Code	10g.	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
36 in 72 hours after death with the N han "matural", or items 23a or iteal Examiner must be notified	mpleted by Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerto  Yes 2 No specify:  dent's Usual Occupation (Give kind of g most of working life. DO NOT use ref	work done	White, etc. Specify:  b. Kind of Business:  Back m	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Meg	To Be	DAM DN MOORE - SON 350  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State crematory or crematory or compared by the compar	Iling Address (Street and Number or ) 5 mary vale position (Name of cemetery, other place) 4. Lion Cem. 4. 2. Name and Address of Facility 3.	Rural Route Number Ad, Bar Date 2-2108	ACK r, City or Town, Stat  Lt mre 0c. Location - City o  Len Sd 1	nd. 21244 rTown, State rune, mD.
Physician 'Medical :aminer		233 Part. Enter the disease, or complications that caused the death. Do not enter failure ust only one cause on each line.  Immediate cause (Final disease or condition resulting in death)  a. Smoke and soot inhalation  Due to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Coust. (Disease or injury that initiated events resulting in death). Last				
be executician an	Physician/Medical	UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic preg	nancy	23d. Date of delive Month	ery Day Year
P.O.	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	1 Yes  24a. Was ar autopsy perform	2 No 3 Property	
tal Rec		25. Was case referred to medical	26.Place of Death (Chec		No 1	Yes 2 No
Division of Vital Records, pital or Attending Physician: The law require ours after death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should b	ition: To Be	examiner? Hospital: Inpatient 2 FR/Outpa  27. Manner of Death Natural 5 Pending FOUND: Day,Year) 1 Natural 5 Pending Investigation Apr 13, 2008  Apr 13, 2008	e of Injury 28c. Injury at Work?	28d. Describe ho subject in fire	ow injury occurred	her:
Division ospital or Atte hours after de inecte of y filled in by to y filled in by to y filled in by to be t	Certification:	3 Suicide 6 Could not be determined (Specific) Townshouse / Power	street, factory, office building, etc.	or Town, Sta	reet and Number or ate) Drive, Baltimore, N	Rural Route Number, City  Id.
		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigations.	occurred at the time, date and place, a	and due to the cause d at the time, date a	(s) and manner as s	tated. the cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of certifier  Jon W Jes Mrs	29c. License number O.C.M.E.		29d. Date signed (April 14, 2008	
ð		30. Name and address of person who comp eted cause of death (Item 23a)	111 Penn Street, Baltimore, I	MD 21201		
Regis		31. Date filed (Month, Day, Year)  APR 1 7 2008  ORIG	inal .			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year April 11, **Physician** 9:40 P. M Lillian Eileen Brann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Keswick Multicare Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 1, 9. Birthplace (State or Foreign Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1928 1 □ M 2 🗙 F 220-30-5046 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State show. r 28a-f show notified at MXYes 2 No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number "natural", or items 23a or edical Examiner must be USA 21211 710 W. 33rd Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Noxema Factory Worker permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other that any injury or other traumation. 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Edna Wiechert Franklin Ellsworth Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1721 Edgewood Road, Parkville, Maryland 21234 James L. Wilson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4/19/2008 Parkville, Maryland Moreland Memorial 4 □ Donation 5 □ Other (Specify) 21. Signatur, of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road, Baltimore, Maryland 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER BREAST KAME hysician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to landed as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner P.O. Box 68760, 8 and Due to (or as a consequence of): burial attending physician certificate be Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 honths? 3 Ectopic pregnancy Month for 4☐Pregnant at time of death detached the 9 ☐ Unknow signed by the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2/1 No 3 Probably 4 □Unknown 1 Yes Completed caponary artery disente 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? /es 2 Yes 26. Place of Death Check onl on 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☐ No 27. Manner of Lean Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred al or Attending Pl after death. I Director: After th Certification: (Month, Day Year) 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L the Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

White and address of person who completed cause of death (Item 23a) (Type, Print)

Affect (Month, Day, Year, APAL / 2 2008)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Affect (Month, Day, Year, APAL / 2 2008)

State Registrar

DHMH 17 Rev 1/2001

5

0

2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite

altimore, Maryland 21215-0036

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notifled at

the Medical B

physician and the burial-tran signed by the has e 2 page certificate rector. this After death.

or Attending Physician: within 24 hours after death

To the Funeral Director: To the Hospital

State

Medical Certification: investigation Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certi

1704

#38

LUTHERVILLE

16 APRIL 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARC I. LEAVEY, 1205 YUZE ROAM MD

31. Date filed (Month, Day, Year) APR 1 7 2008



Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 5:07 P M April 14, Contrino Lee Frances 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🗓 F 213-36-0208 Maryland March 13, 69 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pikesville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 11 North Church Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 12\_years Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Thiess Lillian Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Contrino 12516 Valley Pines Drive, Reisterstown, MD. 21136 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 18, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cemetery 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such es cardiac or respiratory arrest, Immediate Cause (Final EMPHYSEMA MONTHS disease or condition resulting in death) Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

event, the Medical Examiner must be notified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, Ita Meone.

Director

Funeral

2

Completed

Be

ပ္

the Maryland

with 1 6

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a d be detached for

Exami Physician/Medical Completed by Be Certification: To

23b. Was decedent pregnant in the past 12 months? ☐Yes 2XINo 9 Unknown

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

performed? 1 □ Yes 2 🗷 No 26. Place of Death (Check only one)

1 ☐Yes 2 ☐ No

<ol><li>Was case referred to medica</li></ol>
examiner?
1 ∏ Yes 2 🛣 No

27. Manner of Teath

5 Pending investigation 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Natural

2 Accident

4 ☐ Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certification

29c. License number

29d. Date signed (Month, Day, Year) D64395 APRIL 14, 2008

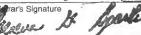
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIENT DIBERMAN, NO 6565 N CHARLES ST, SUITE 209 BALTIMORE, MIS 21204 31. Date filed (Month, Day, Year)

State Registrar

5

Medical



within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 208 +- 1 a 1200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 8. Date of Birth Month, Day, last birthday) **Funeral** Days 1 M 2 N Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" --- " any Injury or other trainment." 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∏Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Itol Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Marda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) -donables 20a. Method of Disposition
1 □ Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or othe 20c. Location - City or Town, State 3 Removal from State (ramison 4 Donation 5 Other (Specify) 21. Signature of Fureyal Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 2 No After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;

completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24hwit 31. Date filed (Month, Day, 32 Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 2. Date of Death Month April 1. Decedent's Name (First, Middle, Last) 14, 2008 11:50 PM Martin L. Dwarkin 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Olney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Jan 28 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Illinois **M** 2□ F 359-26-1292 71 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Colesville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 12809 Broadmore Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Dept Of Defence Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Rubenstein Nathan Dwarkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12809 Broadmore Road Colesville, Maryland 20904 Marion Dwarkin, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/16/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRHAGIC 1 044 disease or condition resulting in death) 1CHOCK Due to (or as a consequence of): GAST RUILTESTI KAL Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown PUCYUITHEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 Yes 2 No NA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Nation 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Physician: The law requires that the death certificate be executed use as the burial-transit and P.O. Box 68760, physician been signed by the attending should be detached for use as Division of Vital Records, certificate or Attending Hospital

Physician

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show

Directo

Funeral

Completed by

Be

မ

Completed by Physician/Medical Examiner

Be

Certification: To

Medical

filed within 72 hours after death with the Maryland

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item ZZ is marked other tiany injury or other traumatic event, ID. 9068.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

cate has l after death.

Director: After this certific completely filled in by within 24 hours a To the Funeral D

State Registrar

31. Date filed (Month, Day, Year) APR 1 7 2008



Dr Line Vern- To we love

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DOUSS541

AP21- 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🗎 🧎 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year Kathryn Chetham April /Medical Drury 16 2008 3:30 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. DEC 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 89 Illinois 321-14-4043 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, BR-102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Harry Alexander Chetham Martha Susan Barrow ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any Injury or other trau Richard Drury - son 14500 Chrisman Hill Drive, Boyds, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/16/2008 Baltimore, MD 21. Signature of Funeral Service Licensee H <sup>22</sup>Chame and Address of Facility
Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ment **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) ed by the a 9□Unknown 9∏Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? 2 NO Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No ဥ 1 Tes 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation or Attending Japhtar 4 hours after des.
-val Director: After 1 Natural Injury 2 Accident 1 ☐ Yes 2 🗀 No the Funeral Directory filled in by the 3☐ Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a honsville Choi6 gre Maiden 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2008 APR 1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10 a. M 200 Douglas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Manor Care Health Care Service Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1-22-1934 9. Birthplace (State or Foreign DC 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral 1**X M 2 □ F Director 578-42-9844 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show treumatic event, the Medical Examiner must be notified at ¥ Yes 2 □ No Director MD Hyattsville Prince Georges or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 USA or Items 23e 6060 Sargent Road #5202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neture." — any injury or other trees. Yar or Dates 51-53 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:Black Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Human Elementary/Secondary (0-12) College (1-4or 5+) Resources 12 Counselor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Smallwood Lenard Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Pats Court, Ft. Washington, Maryland 20744 19a. Informant's Name/Relationship (Type, Print) Harry Tibbs, Jr./Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-17-2008 Laurel, Maryland `4 □ Donation 5 □ Other (Specify) Maryland National 22. Name and Address of Facility Marshall's Funeral Home of Funeral-Service Licensee 4217 9th St, NW, Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardio- zespirate Physician disease or condition resulting in death) /Medical **Examiner** cerebrovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dira to for as a consequence of Examine be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2X No Hospitel or Attending Physician: 24 hours after death. completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Many of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation after death. 1 Tes 2 No 2 Accident Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-9-08 DO05362

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2/01 Sast Heffaton SF Pocky Cle

32. Registrar's Signature

RIVA

Karger Lamanate

0

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Isar Edypusty

Lear Bely Ansky

APR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Muion

32. Resstrar's Signature

Bleeve

29c. License number

AT 2438946 F32

29d. Date signed (Month, Day, Year)

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Jillian DiMarco 2008 3:24am April 14, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Eugene Avenue Essex Baltimore Co. If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Hours 1 ☐ M 2 💢 F 217-03-7025 89 July20.1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Essex 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2 Eugene Avenue 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🐉 ☐ No Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 8th 18. Mother's Name (First, Middle, Maiden Surname) (unk) 17. Father's Name (First, Middle, Last) Wojciechowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul DiMarco (son) 2 Eugene Ave. Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State Bayview Crematory 4-15-2008Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 3d. Date of delivery Month Year Day e contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

April 14, 2008

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

ō

'natural"

r than

27 is marked other ar traumatic event, the

Department of Health Important: If Item 27 any Injury or other th

Director

Funeral

þ

Completed

Be

2

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be Completed Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

after death.

I Director: After this id in by the funeral di

within 24 hours aft To the Funeral Di completely filled in

that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	2009	0622 064 A	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of ( 9 ☐ Unknown	al death 3 □Ectopic	pregnancy	_	23d. Date of delivery  Month Day Ye
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.		o use contribute to the cause of de
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1   Inpatient 2	]ER/Outpatient 3☐ [	Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Numb ate)
	hysician: To the best of my known in the miner: On the basis of examination				e(s) and manner as stated. and place, and due to the cause(s)

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 1 7 2008

Vincenzo Grippo, M.D. 2801 Foster Avenue Baltimore, MD 21224 2. Registr<del>ar's S</del>

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 44315

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Phy C878 4/21/08 Universificate of Death Reg. No. Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WARDS **Allan** Edwards APR11 2778 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSE ITAL RANDALLST UDUL HMERS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-28-1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□F Days Hours 78 Trinidad Director 214-15-0076 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No MD Baltimore Randallstown Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8802 Stephanie Road 21133 USA 14. Race - American Indian, Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 than "natural", or 1 ☐ Yes 2 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government of Trinidad and College (1-4or 5+) Elementary/Secondary (0-12) Public Services permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other traumatic event, the no-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allan Melville ဂ Nora <u>Edwards</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susannah Edwards/wife 8802 Stephanie Road, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place)
Turnine Public Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sangre, Trinidad 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Signa of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METAS PRTSTATE CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No 1 ☐ Yes 2□No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 ☐ No 2NER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

401 010 COURTRIAD RANDALISTMN, MARYLAND 21133 32 /Registrar's Signat

s of person who completed cause of death (Item 23a) (Type, Print)

B002497D

29d. Date signed (Month, Day, Year)

			For State Registrar		State of N	narylar		rtificate d				Reg. No.	2008	12518
	Observation		1. Decedent's Name (	First, Middle, Las	t)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al -	Ethe1		orreste						Apri1	16	2008	8:10 a
?	Examin	er	4a. Facility Name (If no					4b. City, Tow	n, or Locati I <b>SVI1</b> 1			1	ounty of Death	'A
_			719 Maiden  5. Social Security Num				last birthday)	If Under 1 Y	ar If Un	der 24 Hrs.	8. Date of Birt	h	9. Birtho	place (State or Foreign
	Funeral Director		219-28-274		□M 2 <b>X</b> F	91		Months Da	ys Hou	rs Min.	JUN 2	1916	Mary	land
	<u> </u>		Usual Residence of D	ecedent 0b. County		100 Cit	ty, Town or Lo	agtica						I Od. Inside City Limits
	anyia ehov	5	10a. State 1	Baltime	~~~		Catonsv							1 ☐ Yes 2 X No
	28a-1	ect	10e. Street and Numb		)Te		aconsv	10f. Zip Coo	ie			10g. Citize	en of What Cou	ntry?
	3a or		719 Maider	Choice	Lane, HE	<b>-14</b> 5		2122	28				USA	
	be filed within 72 hours after deeth with the Maryland Hygiene. A Hygiene do ther then "natural", or items 23a or 28s-f ehow do other then "natural", or items 23a or 28s-f ehow event, the Maculcal Examinar must be notified at	Funeral Director	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U	I.S. 13.	Was Decedent If Yes, specify (	of Hispanio	Origin? (Spe	cify Yes or No	- 14	I. Race - Ameri Black, White,	
စ္တ	or its	y Fu	1 Never Married		1 ☐ Yes 2 ☐	No	1	1 ☐ Yes 2 🛣			,		Specify:	
8	hours tural',	d by	3 XWidowed 4	☐ Divorced  5. Decedent's Ed	Year or Date:	5:	16a Doco	dent's Usual O	ocupation			16h Kind	d of Business/In	hite
7	in 72	Completed	(Specify	only highest gra	de completed)	-5.\	(Give	kind of work do	one during I	most of workir	ng	TOD: TODI	o o Daoineou	, account
212	r the	E	Elementary/Second	iary (0-12)	College (1-40	or 5+)	Secre	tary				Fun	eral Ho	ome
	0 - 5	ВеС	17. Father's Name (Fi								(First, Middle,			
<u>X</u>	should be filed withir nd Mental Hygiene. marked other then imatic event, the Market of the Market o	일			Smith					Lanche	V.		nsmith	
Maryland 21215-0036	12 sh h end 7 is m fraum		19a. Informant's Nam  Juanita I			_		ng Address (St <b>Kent A</b> v					Town, State, Zij 21228	o Code)
e)	1 end Heett		20a. Method of Dispo-	-	daugittei	20b. I	Place of Dispo	osition (Name o	f		ate		ation - City or T	own, State
JOH L	eges ant of it: if it y or o		1 Burial 2 3		Removal from Sta			matory or other <b>ematory</b>		4/17/	2008	Ba1	timore,	MD
Baltimore,	permit. Peges 1 and 2 should by Department of Health and Menta important: If item 27 is marked any injury or other traumatic av <u>pnce</u> .		21. Signature of Fune						dress of So	ciety	of Mar	y1and	l, Inc.	
	20244		23a. Part1. Enter the	disease, or com	olications that caus	sed the dea	th. Do not en	299 Fre					e, MD 2	21228 Approximate
			shock, or heart: Immediate Cause (Fi	failure. List only	one cause on each	ine.		cholic					51	Interval Between Onset and Death
7	Pnysician /Medical		disease or condition resulting in death)		a Due to (or	as a consec		(000)	(	2010 (1		1201	9	
	Examiner		Commentative line area	lisiana	b									
	D =	ner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate /ing	Due to (or	as a consec	quence of):							
V	ecute and trans	Examin	Cause (Disease or in that initiated events resulting in death) La	jury	C. Due to (er	as a conse	guanaa af\:							
8760,	cate be executed physicien and the burial-transit	al E	<b>,</b> ,,		0) 01 800	as a consec	querice ory.							
		edical			d									
Вох	death certifi e attending   d for use as	N/M	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome			□Estania arasa				2:	3d. Date of deliv	
	0 0 0	sicia	in the past 12 m 1 □ Yes 2 □ l		1⊡Live birth 4⊡Pregnan 9⊡Unknowr	t at time of		⊒Ectopic pregr ⊒ Other (specif					Month	Day Year
P.O.	requires that the de neen signed by the a hould be deteched f	Physician/M	9 Unknown		As annual Color In						oza Dida	abassa us	a contributo to	the agues of death?
	w requires that s been signed b should be det	þ	Part II. Other signific	ant conditions o	ontributing to deat	h but not re	sulting in the i	inderlying caus	e given in F	an I.		obacco us Yes 2□		the cause of death?
Records,	requi	Completed												
3ec	4 5 CI	d H									24a. Was auto perfo		prior to death?	opsy findings available ompletion of cause of
ā	ician: The t certificate he rector, page		25. Was case referre	d to modical					00.5	No. of Dooth	1 ☐ Yes	2210o	1 🗆 Yes	2 □ No
₹	Physician: this certific ral director,	o Be	examiner?		Hospital: 1 □ Inn	atient 2	] ER/Outpatie	nt 3 DOA	Othor		n <i>(Check only i</i> me 5. <b>⊡⊀f</b> esi		☐Other (Spec	(fv)
0	g Phy er this eral c	n; To	27. Manner of Death		28a. Date of I (Month,		28b. Time o		Injury at Work?	4.07	28d. Describe			
io	Attending it death.	atlo	1 ☐ Natural 2 ☐ Accident	5 Pending investigation	1	Duy 1011	,,	М	1 🗆 Yes	2 □ No				
Division of Vital		Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of	Injury - At I etc. (Spec	nome, farm, st rify)	reet, factory, of	fice		28f. Location ( City or To		Number or Ru	ral Route Number,
	pitel	-	29a, Certifier 1	Cartifying Ph	ysician: To the be	ast of my kn	nowledge dea	th occurred at t	he time da	te and place	and due to the	cause(s):	and manner as	stated.
	To the Hospitel or within 24 hours eft To the Funerel Di completely filled in	edical			niner: On the basi and manner	s of examin								
	To the Within To the compl	Me	29b. Signature and to	tle of certifier	/			29c. L	cense num	ber		29d. Date	signed (Month	. Day, Year)
			•	/ N	MI			D	474	4)		460	11)	2008
	10		30. Name and address	ss of person who	completed cause	of death (Ite	om 23a) (Type	Print)	(gn	· Cat	usv:	16	Mar	le
3	Sta Regist		31. Date filed (Month	Day, Year)	32. Reg	Grar's Sign	nature	Speck	,	***				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:30P Mary Flynn 4-10-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Rossville Rosedale

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Balto. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 90 Yrs. Director <u>216-01-3228</u> 9-12-1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Madical Examiner must be notified at</u> 1 ☐ Yes 2 ☑ No Director Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2513 Burridge Rd. Funeral Usa\_ 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes Z No White Maryland 21215-0036 Specify. Specify: ģ 3√ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Sewing Co. Seamstrees 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Linhart Mary Tuma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an
Important: If Item 27 is
any Injury or other trau Charlotte Flynn D-I-L 205 Broadview Avenue BelAir, Md. 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview 4-15-2009 Fallston 21. Signature of Funeral Service Deensee 22. Name and Address of Facility Sun D. Jein 9705 Belair Rd. Schimunek Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** abson 0 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed the attending physician and Earl Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 JH6 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📙 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ö Vital Division hours a To the

ame,

tVior D31444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EYAW St Soute 308 BALTMURE MP

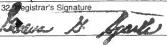
and manner stated.

29d. Date signed (Month, Day, Year) 08

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 17



State

Registrar

29c. License number

0	0	8	E-man of the same	2	5	2	
---	---	---	-------------------	---	---	---	--

		For State Registrar	State of Mar				lental Hy	giene Reg. No. 2	008	1252
rik		Decedent's Name (First, Middle, Acc	lam Roy	Fringer			Month	eath Day 1 15	Year 2008	3. Time of Death 4:14 A
Examinum Funeral Director	ner	Frederick Memor	ial Hospital	(In yrs. last birthday)	Freder	ick	(Month, D	rth ay, Year)	rederick  9. Birthplac	ce (State or Foreigi
1215-UU36 within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at		Usual Residence of Decedent  10a. State 10b. County  MD CARRO  10e. Street and Number  176 SCHAEFFEI  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)  8	AVE .  12. Was Decedent Ev Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:  Education grade completed)  College (1-4or 5+)	WESTMIN  WESTMIN  16a. Decector (Give life. L	ISTER  10f. Zip Code  21  Was Decedent of H f Yes, specify Cuba  I Yes 2 No  lent's Usual Occup- kind of work done of NOT use refired	ispanic Origin? (Span, Mexican, Puerto Specify: ation suring most of work.) IER	ecify Yes or N Rican, etc.)	10g. Citizen  USA 0- 14.	of What Country  Race - American Black, White, etc ecify: WHIT of Business/Indus	d. Inside City Limits  1▼IYes 2□No  y?  Indian, c.
permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even once.	To Be	AD  19a. Informant's Name/Relationship  CATHERINE V.  20a. Method of Disposition  1⊠Burial 2 □ Cremation 3  4□Donation 5 □ Other (Spe	AM ROY FRI  (Type. Print)  FRINGER -W  Gramma State city)	19b. Mailin IFE 176 20b. Place of Dispo- cemetery, cren BAUST CH	g Address (Street a SCHAEFF sition (Name of natory or other place URCH CE	MYRTL  and Number or Run  ER AVE.  M. 4/18  so of Facility FL	E CUMN al Route Numb , WESTN Date / 08 ETCHER	MINGS Der, City or To MINSTE 20c. Locati WESTM R FUNE	own, State, Zip Co ER, MD on - City or Town MINSTER ERAL HO	21157 n, State
Physician /Medical Examiner  the burial-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a of c.	consequence of):	ua			arrest,	l Ir	Approximate nterval Between onset and Death
Hospital or Attending Physician: The law requires that the death certificate hours after death.  Funeral Director: After this certificate has been signed by the attending it led filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Me	25. Was case referred to medical examine?  1   Yes 2   No  27. Manner of Death  10   Natural   5   Pending in vestigat   3   Suicide   6   Could not   4   Homicide   1   Destriving   (Check only one)   2   Medical Examine	Hospital:  28a. Date of Injury (Month, Day )  28e. Place of injury building, etc.  Physician: To the best of aminer: On the basis of e	Petal death 3 me of death 5 me of death 6 me	t 3 DOA Other (specify)	26. Place of Deather: 4 □ Nursing Ho y at Yes 2 □ No	24a. Was auto perfined by the control of the contro	tobacco use of Yes 2 No 2 N	Month Date of the contribute to the contribute to the contribute to the contribute to the date of the contribute of the	y findings available sletion of cause of No  Route Number,  ed. ne cause(s)
	The law requires that the death certificate be executed the three law requires that the death certificate be executed the law requires that the death certificate be executed to be partment of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show the page 2 should be detached for use as the burial-transit on the properties of the page 2 should be detached for use as the burial-transit once.	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.  4 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tell functions are death.  Funeral Director: After this certificate has been signed by the attending physician and tell functions are detached for use as the burial-transit and many injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Physician/Medical Examiner  To Be Completed by Funeral Director	Tendental or Attanding Physician / Medical Examiner  1. Decedent's Name (First, Middle, Activity Name)  4. Frederick Memox Activity Name (If not institution, activity Name)  5. Social Security Number Carried Name (Social Security Number Carried Name (Name Carried Name Carried N	Physician / Medical Examiner  Funeral Director  Proposition   10   10   10   10   10   10   10   1	The Selection   The Selectio	Physician   Indeeded   Physician   Indeeded   Physician   Indeeded   Physician   Indeeded   Indee	Physician   Acam   Roy   Fringer   Jr	Physician   Continue Name (Fret, Midde, Last)   Continue Name (F	December   Adam   Roy   Pringer   Security   Report   Security	Physician   Action   Action   Roy   Fringer   Jr   Denoted to Name (First, Medice), and   Action   A

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFROOKTEH

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITH#23perPHYS., G8/8, 4/1//08, WS

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Greaver **Physician** 8:30A M しんらナロ 8,2008 APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ESSEX 1015 OLD EASTERN AVENUE if Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2 □ F 19 220-31-6992 Yrs. MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar models. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No ESSEX MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 1015 OLD EASTERN AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: WHITE ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GEM CONSTRUCTION ROOFER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be (RYAN) KIMBERLY ANN **GREAVER** DAVID LEE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 HOMBERG AVENUE ESSEX, MD 21221 DAVID L. GREAVER/FATHER 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH | 4-12-08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Adrenal. Disease Onset and Death Immediate Cause (Final disease or condition resulting in death) chenge **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has page 2 No 1 ☐ Yes certificate or Attending Physician: 25. Was case referred to medica examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 D Sesidence 6 ☐ Other (Specify)
1njury at 28d. Describe how injury occurred Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mapner of Death 1 ∰ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: 

Dietely filled in by the death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital 1 A ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D0061907 MD30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Bustimore MD 21221 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene) 2522 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician JEAN** GRIMES 8:10 pM 2008 April 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M Months Days Hours 504-01-8174 89 Director April 4, 1919 South Dakota Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits works 'natural", or items 23a or 28a-f shov dical Examiner must be notlified at 1 ☐ Yes 2 ☑ No Director MD Carroll Sykesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6215 Oklahoma Road 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify. 2 Specify: 3 Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Government than Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Secretary Dept. Of Army and Mental Hygic Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wallace Falconer ပ Bessie Amarilld McKenney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and Inportant: If item 27 is any injury or other trau Michael W. Grimes / son 6215 Oklahoma Road, Sykesville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 8, 08 Arlington Nat. Cem. Arlington, Virginia 21. Signature of Funeral Servi 22. Name and Address of Facility Donaldson Funeral Home, P.A. With / M00773 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the distant ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) Physician Due to ( as a conse wence of) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-transi Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) P.O. the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has t page 2 s autopsy perform certificate 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1. Natural 2 ☐ Accident 5 Pending investigation in 24 hours after user the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 2 Medical Examiner. On the basis of examination and/or investigand majner stated. To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who comdeath (Item 23a) (Typ

Registrar

State

Ø

32. Registrar

alan

Abereuly Ba

31. Date filed (Month, Day, Year)

Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

	_ For	Type or Print in State of Marylar	nd / Depar	tment of Health	and Mental F	_	gible.		
	1 - State Registrar		Cert	ificate of Death		Reg. No.2	108   2523		
Н	1. Decedent's Name (First, Middle, Last	t)		-	Death	3. Time of Death			
n al	JAN			LADDON	APRII		2008 5:45 P. M		
er 🗎	4a. Facility Name (If not institution, give			4b. City, Town, or Location	of Death	4c. Coun	nty of Death		
	FOREST HILL HEALT		NTER	FOREST HI			HARFORD		
	Social Security Number     6. Se	VIM OF E		If Under 1 Year If Under Months Days Hours	Min. (Month,	Birth Day, Year)	Birthplace (State or Foreign Country)		
	067-24-5990	88	Yrs.		03-2	L-1920	Holland		
	Usual Residence of Decedent  10a. State 10b. County	10a C	ity, Town or Loca	ation			10d. Inside City Limits		
Be Completed by Funeral Director	Maryland Harford	100. 0	Joppa				1 ☐ Yes 2X No		
<u>=</u>	10e. Street and Number			10f. Zip Code		10g. Citizen o	of What Country?		
a	519 Newberry Ct			21085		U.S.	Α.		
ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		as Decedent of Hispanic Or Yes, specify Cuban, Mexica	igin? (Specify Yes or		ace - American Indian,		
Ţ	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛪 No					lack, White, etc.		
þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	''	☐ Yes 2X No Specify.	:	Spec	White		
ted	15. Decedent's Edu	ucation	16a. Decede	nt's Usual Occupation		16b. Kind of	Business/Industry		
ple	(Specify only highest grad	College (1-4or 5+)	life. DC	nd of work done during mos O NOT use retired)	st of working				
E	12	College (1-401 54)	Radio	Engineer		Be1	gian Shipping		
ပ	17. Father's Name (First, Middle, Last)		1		er's Name (First, Mide				
To B	Jan Gladpootjes			не	ndrika Bos	2			
Ĕ	19a. Informant's Name/Relationship (7)	ivne Print)	19h Mailing	Address (Street and Numb			un State Zin Code)		
	1 ' '	Granddaughter	-	SE Sharon St					
- 1	20a. Method of Disposition		Place of Disposit		Date		n - City or Town, State		
	1 Burial 2 Cremation 3 I	Removal from State	cemetery, crema	atory or other place)	Date		•		
	4 □ Donation 5 □ Other (Specify,				04-16-2008	_1	more, Maryland		
	21. Signature of Funeral Service Licens		22.1	Name and Address of Facil	<sup>ity</sup> Schimunel	Funera	1 Home of BelAir		
	1 49 00	2		W. MacPhail					
er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only complete the condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner thickerying	a. Due to (or as a consect.)  Due to (or as a consect.)	quence of):	the mode of dying, such as	-	y arrest,	Approximate Interval Between Onset and Death		
ᇤ	Cause (Disease or injury								
Examiner	that initiated events resulting in death) Last	C Due to (or as a conse	quence of):						
m									
g		d							
Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □E	ctopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions co	ontributing to death but not re	sulting in the und	erlying cause given in Part	I. 23e. D	id tobacco use co	ontribute to the cause of death?		
9	alual I la	ll T			1	☐Yes 2☐No	3 ☐ Probably 4 ☐ Unknown		
itec	2								
comple	islites				24a. W au pe 1∐ Ye	itopsy erformed?	b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
Be	25. Was case referred to medical examiner?			26. Place	e of Death (Check on				
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Other: 4 N	ursing Home 5 ☐ R	esidence 6 🗆 C	Other (Specify)		
ion:	27. Manner of Death  1 Natural 5 Pending 2 Naccident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2	28d. Descrit	pe how injury occ			
ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h	l nome, farm, stree ifv)		28f. Location	n (Street and Nur Town, State)	mber or Rural Route Number,		
Cen		January, oto, (Open			Only of				
Medical Certification:		ysician: To the best of my kn ilner: On the basis of examin and manner stated.							
Ĭ	29b. Signature and title of certifier			29c. License number		29d. Date sign	ned (Month, Day, Year)		
	David 5	1		0327	) <	011	147004		

BEL AIR, MD.

21014

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar DAVID DUNN

6

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 1 7 2008

CHIGINAL

615 W. MACPHAIL ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Sibvl Davis Gunther 13, 2008 20:00 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) Days 1 ☐ M 2 🔼 F Months Hours 212-38-2432 87 June 15, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Harford Edgewood 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 207 Kennard Ave 21040 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏂 No Specify. Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Rudisill Davis Gladys May Mincer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Richardson / Friend 207 Kennard Ave., Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Lutheran Cem. 4-19-08 4 ☐ Donation 5 ☐ Other (Specify) Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final ny ocardial disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examilier: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3 □ DOA 1 Inpatient Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Examiner burial-transit for use à. has been signed to 2 should be det page, funeral director,

Hospital or Attending

24 hours after deatle Funeral Director:

To the Hospital or Atte within 24 hours after deg To the Funeral Directo completely filled in by the

Physician/Medical Examiner Completed by Be Certification: To

**Physician** 

/Medical

10a. State

Director

Funeral

Completed by

Be ပ္

Examiner

**Funeral** 

Director

is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at

Important: If It any injury or o

Physician

/Medical

6, Maryland 21215-00

in the past 12 months?

1 Yes 2 No
9 Unknown

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signal 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 | 2525 Jeffrey Shane George 1- For State

		Registrar	<u> </u>	Reg. No.	7			
Physicia	an/	Decedent's Name (First, Middle,Last)	• 60	Date of Death     Month Day Year	3. Time of Death			
ledical Exami	ner	Jeffrey Shane Geo		April 8, 2008	1220 hrs			
100		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death					
		6535 Hilmar Drive # 304	District Heights	. Prince Geo				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday						
Director		220-88-4668 <sub>1</sub> X <sub>M 2</sub> F 33	Months Days Hours Mir	10/03/1974 F	oreign Country) MD			
	ŀ	Usual Residence of Decedent						
any	1	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits			
× .		VA Fairfax	Alexandria		1 Yes 2 X No			
Aaryland 28a-f show	힏	10e. Street and Number	10f, Zip Code	10g. Citizen of What	Country?			
e Maryland or 28a-f sho	Director		22310	USA				
h the		6132 Valley View Drive						
h wit	uneral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 13.	Was Decedent of Hispanic Origin? (SIf Yes, specify Cuban, Mexican, Puert	specify Yes or No- o Rican, etc.) 14. Race - A White, e	merican Indian, Black, tc.			
or its	μ	1 Yes 2 X No	— <b>-</b> V		white			
after	ğ	or Dates:	Yes 2 No specify:					
hours natu	ᄝᅵ	dunn	dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		ess/industry			
16 n 72 nan "	omplete	Elementary/Secondary (0-12) College (1-4 or 5+)	artender	Enterta	inment			
5-0036 iled within 7 Hygiene. I other than	m				Timent			
Hygh oth	ပ	17. Father's Name (First, Middle, Last)  Eddie Wayne George		e (First, Middle, Maiden Surname) Larrick				
21215-0036 uld be filed within 72 hor Mental Hygiene. marked other than "nat c event, the Medical Exa	Be c		illing Address (Street and Number or		State 7in Code\			
D 21 should and Me	5		2 Valley View Dri					
and 2 shou tealth and P tem 27 is n		(mother)	position (Name of cemetery,	Date 20c. Location - Ci				
Baltimore, MD 21215-0036  Department of Health and Mental Hygien 72 hours after death with the Maryland Department of Health and Mental Hygien 4.  Important: If item 71's marked other than "natural", or items 23a or 28a-f she migner yor other traumatic event, the Medical Examiner must be notified at once night.		1 V Buriel 2 Cremation 3 Removal from State crematory of	r other place)					
Page nent c		Mt. Comi		/12/2008 Alexand				
Baltimo permit. Pag Department Important: injury or ot		21. Signatore of Finaral Service Licensee	2. Name and Address of Facility	emaine Funeral Ho	me			
<b>w</b> §9 [i		- Know of Nouse		, Springfield, VA				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and			
/Medical		Immediate Cause (Final disease a. Hand and Neck Injuries			Death			
xaminer		or condition resulting in death)  Due to (or as a consequence of):						
		Sequentially list conditions, b						
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
,	am	(Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of):	-					
1 g g g g g g g g g g g g g g g g g g g		d.			_			
68760, Scrifficate be executed and noting physician and use as the burial - transit	an/Medical	UNPENDED AMENDED						
30, te be sysicii buria	led	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery			
876 tiffica ng ph	5	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregi		Day Year			
x 6 h cer tendi		4 Pregnant at time of death 5	Other (Specify)					
Box e death of the atter ed for us	Physici	1 Yes 2 No 9 Unknown g Unknown						
P.O. Box 687 that the death certifined by the attending detached for use as it		Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacco use contribu				
, P.C ires that signed I	d by			1 Yes 2 No 3	Probably 4 Unknown			
ords, w requir s been s should	Completed				ere autopsy findings available			
COF law r has t	npl			performed? dea	or to completion of cause of ath?			
Vital Rec ssician: The l his certificate l director, page	Co				Yes 2 No			
tal cian: certif	Be (	25. Was case referred to medical examiner?	26.Place of Death (Chec					
of Vital Records,  ng Physician: The law require ther this certificate has been si meral director, page 2 should b	To	1 Yes 2 No Inpatient 2 ER/Outpa		sing Home 5 Residence 6				
1 of V ding Ph. After tl funeral		27. Manner of Death         28a. Date of Injury         28b. Time (Month, Day Year)           1 Natural         5 Pending         Apr 8, 2008         0000 hr		28d. Describe how injury occurred Subject assaulted	1			
Division ial or Attendi rs after death. al Director: /	atio	1 Natural 5 Pending Apr 8, 2008 0000 hr	1 Yes 2 V No					
Vis or At of At Orec in by	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City			
Divisipital or At ours after der differed Direct filled in by	Certification:	4 🗸 Homicide determined (Specify) Multi-Family Apt.		6535 Hilmar Drive # 304, Distr	rict Heights, MD			
Hos 24 hc Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, a	nd due to the cause(s) and manner a	s stated.			
Division of Vital Records, P.O. Box with the Hospital or Attending Physician: The law requires that the death within 24 bours after death. To the Functal Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	edical	one) 2 Medical Examiner: On the basis of examination and/or investand manner stated.	tigation, in my opinion, death occurred	d at the time, date and place, and due	e to the cause(s)			
F 3 F 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)			
		1/2/2	O.C.M.E.	April 9, 2008	3			
		30. Name and address of person who completed cause of death (Item 23a)			*			
. ^		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
(h)		Zabiullah Ali, M.D. Assistant Medical Examiner 111 l						
10	tate		enii Street, Daltinore, MD 2	. 1201				

DHMH 17 Rev 1/2001

12

Registrar

**ORIGINAL** 

600 Ridgely Avenue # 231 Annapolis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D.

2008

32. Registrar's Signature

Chopra

APR 17

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 7, Year **Physician** 2008 Robert Aydelotte Henley 5:10 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 121 | lene Rd . Social Security Number Glen Burnie If Under 1 Year | If Under 24 Hrs. Anne Arundel 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** 1√√M 2□ F Months Days Hours 217-62-0339 Director Feb 4, 1952 56 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f show 1 □Yes 2/2/No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21060 121 Hene Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2 ₩No Specify. ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hyglen Important: If item 27 is marked other thany ny or other traumatic event. Utiliquest Damage Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Elizabeth Irene Robinson John Edgar Henley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Hene Rd, Glen Burnie, MD 21060 Patricia Henley Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr 12, 2000 Baltimore, MD Bayview Crematory 21. Sign of up of Funeral Syrvice Lic 22. Name and Address of Facility
Fink Funeral Home, P.A. 1401148 426 Crain Hwy S., Glen Burnie, MD Gregory Approximate Interval Between Onset and Death 23a. Part i Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of) Examiner attending physician and for use as the burial-transit HYPERTENSION yrs that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) □Yes 2□No o. s been signed by the should be detached 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Completed Were autopsy findings available prior to completion of cause of death? cate has l page 2 s ATRIAL FIBRILLATION autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2/1X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27 Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 ☐ Yes 2 □ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D54292 4/11/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 CRAIN HWY SUITE 610 GLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) egistrar's Signature 32. State 2008 Registrar

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: n 24 hours after dec he Funeral Directo pletely filled in by th To the Function To the within 2

.0	•				autopsy	prior to completion of cause of	
Cler	ebral	lufarch	ion		performed? 1□ Yes 2 🗗 No	death? 1 □ Yes 2 ☑ No	
25. Was çase refer	red to medical	(KE)		26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1   Inpatient 2	]ER/Outpatient 3□ [	Home 5 ☐ Residence 6	ne 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Dea 1 ☐ Matural 2 ☐ Accident	th 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,	
29a. Certifier (Check only one)		hysician: To the best of my kno miner: On the basis of examina and manner stated.					

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

and address of person who completed cause

31. Date filed (Month, Day,

32. Registrar's Signature



Medical

State Registrar 08-02752 Kristy Holter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

isty Holter	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg, N	. 2008 1252
Physician/	Registrar 2 Date of Death	3. Time of Death
edical Examiner	Kristy Marie Holter April 8, 2008	4c. County of Death
Milia.	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Baltimore	N/A
Funeral Director	5. Social Security Number 106-56-2526   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(M Months   Days   Hours   Min.   01-05-10	M/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
<b>b</b>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
d Se.	Maryland N/A Baltimore	1 X Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Memal Hygiene. The sinamked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once. TO Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?
with the as 23a contif		14. Race - American Indian, Black, White, etc.
r death with or items 23 must be no	Armed Forces?    1   X   Never Married   2   Married   Armed Forces?     Yes   2   X   No     3   Wildowed   4   Divorced If Yes, Give Year   1   Yes   2   X   No   specify:	Specify: white
urs afte tural", aminer	3	b. Kind of Business/Industry
16 n 72 ho nan "na isal Ex	Total Decedent's Education (Specify Only Ingrises glade dempises)   Specific Decedent's Education (Specify Only Ingrises glade dempises)   during most of working life. DO NOT use retired)	Health Care
d withing ygiene.	To Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maidle, Maid	
21215-0036 uld be filed within 77 Mental Hygiene. marked other than event, the Medical	unknown unknown	. City or Town, State, Zip Code)
MD 2 d 2 shoul lih and M n 27 is m aumatic	Margaret Campbell, mother 335 S. Monroe St. Baltimore	, MD. 21223
- p = e = i	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Description 5 Other Space(f):  20b. Place of Disposition (Name of cemetery, crematory or other place)  West Arundel Crematory 04-14-08	Oc. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		Odenton, MD
Bal Perm Depa Impo injur	1328 Sulphur Spring Rd. Ar	butus MD 21227 shock, or heart Approximate Interval
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line.	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Tramadol Intoxication  Due to (or as a consequence of):	
	Sequentially list conditions, b. Due to (or as a consequence of):	
	E couse. Et let Underlying Couse (Disease or injury that initiated C.	
cuted and transit		
60, ate be executed hysician and e burial - transit	MENDED 23a,27,28a-f per ME g878 4/21/08 amh	23d. Date of delivery
iox 68760, eath certificate be ex attending physician for use as the burial for the certificate the certificat	AMENDED 23a, 27, 28a-f per ME g878 4/21/08 amh  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  AMENDED 23a, 27, 28a-f per ME g878 4/21/08 amh  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 9 Unknown 9 Unknown 23e. Did toba	Month Day Year
Box 687( c death certification the attending place as the	Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown	
P.O. B es that the d igned by the be detached		acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
w requires t as been sign should be	24a. Was an autopsy perform 1 Yes 2  26 Place of Death (Check only one)	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  "al Director: After this certificate has been simply and the funeral director page 2 should the first this companies."	perform 1 ✓ Yes 2	ed? death?
Vital Rec ysician: The l his certificate director, page	25. Was case referred to medical	esidence 6 🗸 Other: Scene
Physic er this cral dire	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d. Describe ho	
on of ending Ph. anh. After the funeral	1 Natural 5 Pending (Month, Day,Year) 1 Yes 2 X No link Investigation Investigation Fnd 4/8/08 Fnd 6;30a	
Division pital or Attencours after death teral Director: filled in by the	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Str. or Town, Sta	eet and Number or Rural Route Number, City te)
ig bou		(s) and manner as stated.
To the Hos within 24 h	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date an and manner stated.	nd place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
		April 8, 2008
	30. Name and address of person who completed cause of death (Item 23a)	
	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr	tate 31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar		(	Certific	ate of	Death		Re	g. No.	008	125	530
	3400		1. Decedent's Name (First, Middle,	Last)						Date of Death Month	n Day	Year	3. Time of	
	Physicia /Medic	-	WILLIE	JEAN HOUSTON						pril	10	2008	6:35	P M
	Examin	1/4	4a. Facility Name (If not institution,	give street and number)		4b. (	City, Town, o	r Location of D	Death		4c. C	ounty of Death		
			13029 Old Stage	Coach Rd, #272	21		Laure		000 1 -		Pr	ince Ge		
	Funeral			5. Sex 7. Age (In yrs. 1 ☐ M 2 🖫 F	last birth	Mon	ths Days	If Under 24 Hours		Date of Birth (Month, Day,		Coui	olace (State o ntry)	r Foreign
120	Director		454-94-7753	58	3 "	rs.			S	ept. 9	, 19	49 Tex	as	
	and w	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town	or Location						1.	10d. Inside Cit	ty Limits
	laryla sho	5				1							1 □Yes	2 1 No
	he N 28a-f otifie	Director	MD Prince	George's	Laure		. Zip Code			10	n. Citize	en of What Cou	ntry?	
	a or be n			0 1 7 7 8		10	,						,	
	s 23	Funeral	13029 Old Stage	12. Was Decedent Ever in U		13. Was E	207	08_ Iispanic Origin	n? (Specify	Yes or No-	USA 14	1. A. Race - Americ	can Indian,	
	Item Iner	'n.	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		If Yes,	specify Cub	an, Mexican, F	Puèrto Rica	an, etc.)		Black, White,		
36	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Y	es 2 <b>XM</b> No	Specify:			8	Specify: Bla	.ck	
ŏ	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. If Health and Mental Hyglene trems 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		15. Decedent's	Education	16a. [	Decedent's	Usual Occup	oation during most o	of working		16b. Kind	d of Business/In	dustry	
21215-003	hin 7 s. an "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	- '	life. DO NO	T use retire	d)	i working					
2	d wit gien er the	οū	12th	ø	Pri	nt Sh	iop/Co	oy Mana				Governm	ent	
b	othe vent,	Be (	17. Father's Name (First, Middle, L	ast)				18. Mother's	s Name (Fi	irst, Middle, N	faiden S	Surname)		
<u>a</u>	uld b Menta rrked rtic e	To E	Willy Henry,	Jr.					Kath	<u>erine</u>	News	ome		
Maryland	sho sand l		19a. Informant's Name/Relationshi	p (Type. Print)	19b.	Mailing Add	lress (Street	and Number	or Rurai R	oute Number,	City or	Town, State, Zi	) Code)	
	and 2 salth 27 I er tra		Edward L. Houst					ge Coac		- " -		aurel,		708
ore	of He		20a. Method of Disposition 1XX urial 2 □ Cremation		Place of I cemetery	Disposition r, crematory	(Name of or other pla	ce)	Date	' '	20c. Loc	ation - City or T	own, State	
Ĕ	permit. Pages 'Department of H Important: If Ite any Injury or of		4 □ Donation 5 □ Other (Sp	- MI	Vet	erans	Cemet	ery 4/	22/20	008	Chel	tenham,	Maryla	and
altimore,	mit. partn ports y inju		21. Signature of Funeral Service L	icensee		22. Nan	ne and Addre	ess of Facility	Dona	ldson	Fune	ral Hom	ie, P.A	١.
m	o a m		Daniel	\$300 (MO:	1103	313	Talbo	tt Aver	nue,	Laurel	, MD	20707		
h			23a. Part1. The term the disease, or construction shock, or heart failure. List of	complications that caused the dea	th. Do no	ot enter the	mode of dyi	ng, such as ca	ardiac or re	espiratory arre	est,		Approximat Interval Bet	e ween
	Physician		Immediate Caure (Final disease or condition	Arterio								e	Onset and I	Death
1	/Medical		resulting in death)	Due to (or as a conse										
Ø.	Examiner		Sequentially list conditions	b										
-	₽ #	iner	Sequentially list conditions, if any leading to import a cause. Enter Underlying Cause (Disease or injury that is the cause of the caus	Due to (or as a conse	quence of	f):								
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		D.								
90	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit		1000000	Due to (or as a conse	quence o	1).								
68760,	sate to	Medical	·	d										
9 ×	ertifii ding p	_	IF FEMALE:	23c. If yes, outcome pf pregi	nancy						0.	Od Data of dali	ion.	
Bo	ath cath	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death		pic pregnand er <i>(specify)</i> _	y			2	3d. Date of deliv Month		Year
P. O.	the de	Physician	1 □ Yes 2 X No 9 □ Unknown	9 Unknown	death	o 🗆 o an	. (opcony) _							
۵.	that the second second	유	Part II. Other significant condition	ns contributing to death but not re	sulting in	the underly	ing cause gi	ven in Part I.		23e. Did tol	oacco us	se contribute to	the cause of	death?
Records,	w requires that the d been signed by the should be detached	Completed by	Diabetes						- 1	1 □ Ye	es 2	]No 3∏Pro	bably 4 🔀	Unknown
Ö	v requence	ete								24a. Was a	n	24b, Were aut	onsy findings	available
He G	he fav	ם							-	autops perforr	ned?	prior to c death?	ompletion of c	cause of
g	n: Ti ficate r, pa		OF Man ages referred to modical					00 Pines	6 Dooth /		MXNo	1 □ Yes	2 <b>X</b> XNo	
Vita	Physician: The faw r this certificate has t ral director, page 2 s	Be c	25. Was case referred to medical examiner?  1 2 No	Hospital: 1 ☐ Inpatient 2 [		patient 3	J DOA Ot	hor:		heck only on		☐Other (Spec	i6d	
ō	Phy er this eral d	-: To	27. Manner of Death	28a. Date of Injury	28b. T	ime of	28c. Inju	ıry at		I. Describe ho			19/	
OU	nding th. :: Afte	tio	1 Natural 5 Pending 2 Accident investig	(Month, Day Year) ation	ın	jury N	Wo	nk? ]Yes 2∐No	0					
Division or	Atter r dea ector by the	ifica	3 Suicide 6 Could no 4 Homicide determine		home, far	m, street, f	actory, office		28f	Location (Si	treet and	Number or Ru	ral Route Nur	mber,
5	al or s afte	Certification:	4 [] Hornicide	building, etc. (oper	nty/					Only or Town	i, blate,			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it		29a. Certifier 1 Certifying	Physician: To the best of my ki	nowledge,	death occ	urred at the t	ime, date and	place, and	d due to the c	ause(s)	and manner as	stated.	's)
	the H iin 24 the F	Medical	one)	and manner stated.										,
	With Con	Σ	29b. Signature and title of certifier	111	-			se number				signed (Month		0
)	-VI		Sarodo	1/2/2/4	00		142	253	927	7 .	Hpi	1/14	, 200	>8
	12		30. Name and address of person y	vho completed cause of death (Ite	em 23a) (* 20/	//	126	12.		1	6.	.;/14 elg	MA	
	1.		31. Date filed (Month, Day, Year)	32. Registrar's Sig		Hos	100 (a	( 91	ine,	, 🕓	20	ery,	1.00	*
	Sta Regist		ADD 1 7		K	book	20		•			4		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕕 🗍 💍 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL የ4 20 68 **Physician** 9:29 a M REGINA MARIE HAJEK /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 117 ELINOR AVENUE NOTTINGHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ **X** 11/19/1949 MARYLAND 56 7430 58 217 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt; If item 27 is marked other than "natural" or orbitlified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD BALTIMORE NOTTINGHAM Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 117 ELINOR AVE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECURITY 12 0 EVENT STAFF SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sr. RAMONA CIREO **JAMES** J. HAJEK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 117 ELINOR AVE BALTIMORE, STEPHANIE KLEIN /SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/16/08 BALTIMORE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Strvice Icensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** A-teriosciones disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【No 24a. Was an has page 2 autopsy performed certificate 1∐ Yes 2**%** No Physician: director 25. Was case referred to medical 26. Place of Death Check onl one Be examiner' Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Yes 2□ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,~ Funeral Director: tely filled in by the hours after within 24 h 0

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

one)

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar a Signature

30. Name and address of person who completed cause of death/(Item 23a) (Type, Print)

tello

Year!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day CATHI FAYE HORST APRIL 13, 2008 7:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 145 Versailles Court Apt. F Towson Baltimore 5. Social Security Number If Under 1 Year
Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Director 213-15-6909 36 25, 1971 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Ex miner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 Versailles Court Apt. F 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 212/5-0036 1 ☐ Yes 2 No Specify þ Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant VP Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul L. Horst Jr. Brenda S. Bratton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4760 Water Park Drive, Belcamp, Maryland 21017 ce of Disposition (Name of Date 20c. Location - City or Town, State Brenda S. O'Brien/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Buri≰l 2 ☑ Crenfation 3 ☐ Removal from State Hilltop Service Corp. 4-19-08 4 □ Doration 5 □ Other (Specify Towson, Maryland 21. Sign ure of Fune McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 art1. Enter the disease, in complications that caused the death, hock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** woundlo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsv page performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred self in lice 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending 5 ☐ Pending investigation Injury 1 Natural 1930 P M death. April 13,2008 1 ☐ Yes 2 No 2 Accident Twound to Chest within 24 hours after death To the Funeral Director: the *sunshi* 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) (45 USS :: IIIS CITC COMESON, MC 2(204 filled in by Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 leted cause of death (Item 23a) (Type, Print) Philip Milit :11 CT. Luthonville rimblell حا اھ 31. Date filed (Month, Day, Year) State 7

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Jordan G. Hardaway 04 2008 3:03a. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 93 Director 212-09-5693 03 22 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, Inc. Modical Exercitor must be notified at Director MD Howard 1 ☐ Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10302 Boca Raton Drive 21042 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 1 □Yes X X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 is marked other than "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: Black If Yes, Give Year or Dates: ¾☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>9th grade</u> <u>Steel Worker</u> Bethlehem Steel Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic manner. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Hardaway Love Hobson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 19a. Informant's Name/Relationship (Type. Print) Linda Jones-Daughter 10302 Boca Raton Drive, Ellicott City, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/18/08 Randallstown, Md 21. Sign tury of Euneral Service Licensee 22. Name and Address of Facility
March F/H West Somour 4300 Wabash Ave, Baltimore, Md ard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition resulting in death) ACUTE SYNDROME CORONARY Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician the burial Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year 5 ☐ Other (specify) signed by the a o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌿 Unknown CHRONIC OBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number D 28656 30. Name and actiness of person who completed cause of death (Item 23a) (Type, Print) ROAD #208 ROCK VILLE MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Marylar	-	artment d <i>tificate</i>			lental Hy	2.0	0.8	12531
			Decedent's Name (First, Middle,)	Last)			imoato	0, 50	aur	2. Date of De.	Reg. No.← U	0.0	3. Time of Death
	Physici	an		-						Month is	Day	Year	3:30P. M.
4	/Medi		Patricia Anne H  4a. Facility Name (If not institution, s		nharl		4b City Toy	en orlo	ation of Death	April	4c. County	of Dogth	
1	Examir	ier			,		-						
			Baltimore Washin  5. Social Security Number 6	Sex Med	1Cal Ce 7. Age (In yrs.		Glen		11e Under 24 Hrs.	8. Date of Birt	Anne		
	Funeral Director		214-84-2214	1 ☐ M 2 🔀 F		Yrs.			lours Min.	(Month, Da	y, Year)		place (State or Foreign intry)
			Usual Residence of Decedent		39					Jan. 7	, 1969	Mary	land
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Man 	ţ	Maryland Anne A	rundel	Cl	en Buri						i	1 ☐ Yes 2X No
	28a	Director	10e. Street and Number	Edilder		en bur	10f. Zip Co	de			10g. Citizen of	What Cou	intry?
	3a o		124 Touring Manage				210	000		_			
	ne 2;	era	134 Louise Terra	TT	edent Ever in U	.S. 13. V		060 of Hispa	nic Origin? (Sp	ecify Yes or No	Jnited S	<u>state</u> e-Ameri	can Indian,
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "neturel", or teme 23e or 28e-f show event, the Medicel Eversities must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2 ⊠No ∕e	1	Yes, specify	Cuban, M	lexican, Puerto pecify:	Rican, etc.)		ck, White, y:	, etc.
Ö	2 hou	ed	15. Decedent's	Education		16a. Deced	lent's Usual C	ccupation	1		16b. Kind of B		ite ndustry
15	nin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)		40451)	(Give	kind of work a OO NOT use r	lone durin etired)	g most of work	ing			•
27	r the	E	12	College (1	-401 5+)	Billir	ng Anal	vst			Insura	ince	
D	Hyg ent,	Bec	17. Father's Name (First, Middle, La	st)					Mother's Name	e (First, Middle,	Maiden Sumar		
Maryland	12 should be filed within h and Mental Hygiene. 7 ie marked other then " traumatic event, the Me	To B	Frederick N. Ste	ern				D	oreen E	onteyne	2		
3	s 1 and 2 should f Health and Mer flem 27 ie marke other traumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Si				er, City or Town,	State, Zi	p Code)
	and 2 salth a n 27 io		Arthur Charles I	Jook / U	achand								
စ်	s 1 and 2 of Health item 27 i		20a. Method of Disposition	ieck / no	20b. F	Place of Dispo	Jouise sition (Name o	of		oate Bur	20c. Location		
altimore,	nt of nt of r: H i		1 Burial 2 Cremation 3		State	emetery, cren		r place)	Apri]	16, 2008		,	
Ħ	it. P		4 □ Donation 5 □ Other (Special Signature of Funeral SefvicerLie		Met	ro Cre			F	2008			Maryland
Ba	permit. Peges 1 Depertment of H Important: If ite eny Injury or ot once.		> /www.	bay		Ki	rkley- l Crai	Rudd n Hw	ick Fun	eral Ho	ome, P.A Burnie,	MD	21061
П			23a. Part1. Enter the disease, or co shock, or heart lailure. List on	mplications that c ly one cause on e	aused the deat ach line.	h. Do not ente	er the mode of	dying, su	ich as cardiac	or respiratory ar	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	10	nmi	SARI	onA						Onset and Death
	/Medical		resulting in death)	a. Due to	or as a conseq		- IVI						
	Examiner		Commentation for the second field	b									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ог яв в полиес	uanea of):							
9.	cuted	Examiner	Cause (Disease or injury that initiated events	C									
ó	exector and arrigital-ti		resulting in death) Last	Due to (	or as a conseq	uence of):							
8760,	icate be executed physicien and s the burial-transit	cai		d.									
9	iffical g phy as th	edi											
D. Box	at the death certific by the attending p tached for use as	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		inth 2 ∐ Feta ant at time old	death 3	Ectopic pregn Other (specif					te of delive	ery Day Year
P.0	that the	P.					4-4			00 - Did.			
ords,	w requires that the been signed by th should be detache	ted by	Part II. Other significant conditions	contributing to de	au but not res	uiting in the un	derlying caus	a given in	Раπ I.	238. Dia to	1.		he cause of death? bably 4 []Unknown
Vital Records,	The law ete has b page 2 s	Completed								24a. Was autop perfor 1 \( \text{Yes} \)	rmgd?	Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of
įta	Physicien: Th this certificete ral director, pag	Be (	25. Was case referred to medical examiner?			779		26.	Place of Death	Check only o	-		
of <	S S D	P	1 ☐ Yes 2 No	Hospital: 1XII	npatient 2 🗆	ER/Outpatient	3□ DOA	Other: 4	☐ Nursing Ho	me 5 Resid	ience 6 🗆 Oth	er (Specii	fy)
ion o	Attending Pl r death. ector: After th by the funera		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat		of Injury h, Day Year)	28b. Time of Injury		Injury at Work? 1  Yes		28d. Describe h	now injury occur	red	
Division	PA	27. Magner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury of Injury M 1 Yes 2 No 28d. Describe how injury of Injury M 28d. Describe how injury of Injury M 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? City or Town, State)									er or Rura	al Route Number,	
	Hospital     24 hours a     Funerel E letely filled	edical (	29a. Certifier Certifying I	Physician: To the aminer: On the ba	best of my kno isis of examina er stated.	wledge, death tion and/or inv	occurred at the	ne time, d my opinio	ate and place, n, death occurr	and due to the ded at the time, o	cause(s) and ma date and place,	inner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Lie	cense nu	mber		29d. Date signe	d (Month,	Day, Year)
	,- ,F 0		) do to		mo		1	142	677		Da-1	11(	- 7000
	N.		30. Name and a die o person wh	o completed caus	anf death (Item	23a) /Tunn 1	Print)	177	111		5357	17	2~.
	7		apple Olesting.	50/ 1/130	talo	ive, Gle	n Bw	we	+ ND	2061	1		
	Sta Registr		31. Pate filed (Month, 'Day, Year)  APR 1 7	2008	glstral's Signa	ture	2063					-	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 13, 2008 5:10 A<sup>M</sup> April Clifton Harry Johnson, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Forest Haven Nursing Home Catonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 08/29/1927 215-24-2158 80 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Exaπiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 U.S.A. 101 Sandy Beach Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945 – 1 Pres 2 No. 1946 – 1 Pres Give 1946 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗹 No White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johnsons Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator 10 Trucking lith and Mental Hygie 27 is marked other in traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifton Harry Johnson, Sr. Margaret Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 101 Sandy Beach Drive, Pasadena, MD 21122 Department of Health Important: if item 27 any injury or other tr Son Lawrence C. Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/08 | Crownsville, MD MD Veterans Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hematoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse wence of): Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown is certificate has then signed cirector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No The law autopsy performed? 2□No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) NWISING Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2□ No Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1 Naturai 5 Pending investigation **Volume**Volume

Volume

1

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) fal 1 ☐ Yes 2 No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 70/Edmonson AUC Catons U; II e, MD 21228 determined 4 Homicide Nursing Home within 24 hours a To the Funeral C

Vital Records, P.O. Box 68760, 0 Division

Maryland 21215-0036

Baltimore,

DHMH 17 Rev 1/2001

completely

the

Medical

State

29a, Certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, described he occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GTRIMBLE HILL CT. LUTHERVILLE, MU 322 Registrar's Signature

**Examiner** Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Examiner	Sequentially list conditions, if any, leading to min-rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of).	and wompy	Why				
	resulting in death) Last	Due to (or as a consequence of):						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect 4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown ,	opic pregnancy ner (specify)		23d. Date of delivery Month Day Year			
ð	Part II. Other significant condition	s contributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to the cause of death?			
Completed				24a. Was an autopsy performed?				
Be (	25. Was case referred to medical examiner?	Hospital: A	th (Check only one)					
0	1 ☐ Yes 2 No	ome 5 Residence	ce 6 □Other (Specify)					
	27. Manner of Leath Natural 5 Pending 20 Accident investiga	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
cermicanon.	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		factory, office	28f. Location (Street a City or Town, Sta	f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	i Physician: To the best of my knowledge, death occaminer: On the basis of examination and/or invest and manner stated.	, and due to the cause( rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)				
í	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)			
	A STATE	mp	D43977	App	ry 112008			
	Choken they've	no completed cause of death (Item 23a) (Type, Prin	Clen Brom	e mo	7061.			
e r	31. Date filed (Month, Day, Year)	I Rethstrar Usight ure						
1								
		ORIG	NAL					

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Eor	Please	e Type or Pri State of M			Indelible Ink partment of H				_	3 12537
		For State Registrar					ertificate of			Reg. No	2001	0 12001
Physici	an	1. Decedent's Nam	ne (First, Middle, I	Last)					2. Date of D Month	eath Da	ay Year	3. Time of Death
/Medic		Regina J							April	9	2008	8;00 A. M
Examin	er			give street and number,	)			r Location of Death	1	40	County of De	ath
Funeral		5. Social Security N	folk Avenu Number 6.	Sex 7. A	ge (In yrs. la	st birthd	Baltimo	If Under 24 Hrs.	8. Date of B	irth .	n/a 9. Bi	rthplace (State or Foreign
Director		217-20-753	1	1□M 2X F	84	Yrs	Months Days	Hours Min.	(Month, E May 1	8, Ye <i>ar,</i>	23	MD
pu *		Usual Residence o	f Decedent 10b. County		10c. City,	Town or	Logation					10d. Inside City Limits
Aaryle f shored at	ō	MD	n/a			imore						Y Yes 2 No
the N	Funeral Director	10e. Street and Nu			1		10f. Zip Code			10g. Ci	itizen of What C	ountry?
h with	al D	927 N. R	osedale St	reet			2121	.6			USA	
ems ems	ner	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	. 1	Was Decedent of H     If Yes, specify Cuba	lispanic Origin? (Span. Mexican, Puerto	pecify Yes or N o Rican, etc.)	0-	14. Race - Am Black, Whi	
s afte	by F	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married	1 ∐Yes 2 🗖 If Yes, Give			1 □Yes 2 ☑ No	Specify:	, ,			ican-American
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Modeal Examina must be notified at	edk	21		Year or Dates:		16a. De	ecedent's Usual Occup	eation		16b. F	Kind of Busines	
hin 72 e. an "na	plei	(Spec	15. Decedent's ocify only highest g	grade completed)  College (1-4or	5+)	life	ive kind of work done e. DO NOT use retired	during most of worl d)	king		1 . 2 1 . 7	1
ed wit ygien <b>er th</b> :	Completed	12th				Sei	rvice				schild Ko	ohn's
be fill ntal H ed oth even	Be	17. Father's Name	, , ,	st)				18. Mother's Nam		e, Maidei	n Surname)	
hould id Me mark matic	은	William Ho 19a. Informant's N		(Time Print)	· I	10b M	ailing Address (Street	Pauline Ho		hor City	ar Tawa Stata	Zin Cada)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Evanded or the Infect of one.		LaJene P. J					Norfolk Aver				or rown, state,	21p Code)
item		20a. Method of Dis	•		20b. Pla		sposition (Name of crematory or other place		Date	_	ocation - City o	r Town, State
Page Trent ant: If ury or			☐ Cremation 3 5 ☐ Other (Spec	☐ Removal from State cify)	!		n Forest Vete	i	)8	Owi	ngs Mills	s, MD
ermit. eparti nporti ny inj		21. Signature of Fu	uneral Service Lic	ensee	/	-	22. Name and Addre			1 Han	ne P.A. of	Balto. Co.
<u></u>		DICA	LOUN	M. Cle	Mu		9200 Liberty				133	
		shock, or hea	art failure. List on	mplications that cause ly one cause on each l	ine.				or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	on	a. OUA  Due to (or as	~ \ A !		CANCEN					2 mo- 4
Examiner	8				a conseque	nice on.						h.
₽\\/ ≒	iner	Sequentially list co if any, leading to in	inditions, nmediate	b Due to (or as	a conseque	nce of):						
ecute and -trans	Examiner	Cause (Disease or that initiated events resulting in death)	r injury s	C								
be ey		,		Due to (or as	a conseque	ince on:						
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medica			d								
h cert ending use a	IN/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome			2 - Cotonio magazano				23d. Date of d	elivery
e deat	sicia	in the past 12 1 ☐ Yes 2-	MO	4 Pregnant a			3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		- 8	Month	Day Year
ires that the de signed by the	Phy	9 Unknown				in in th		en in Deut I	220 Did	tabassa	uno nontributo	to the cause of death?
ires the signer of the d	l by	rait ii. Other signi	neant conditions	contributing to death b	out not result	ing in the	e underlying cause giv	en in Part i.				Probably 4 Unknown
w require s been si should t	Completed								24a. Wa			
he law e has	duic						<del>\.</del>		auto	opsy ormed?	prior to death?	
ian; T	Be Co	25. Was case refer	rred to medical				<u> </u>	26. Place of Dea	1 ☐ Yes		0 1 □ Ye	s 2 No
Physician; The la r this certificate ha ral director, page 2		examiner? 1 ☐ Yes 2 ⊡	1100	Hospital: 1 ☐ Inpati	ient 2 🗆 E	R/Outpa	tient 3 DOA Oth				6¥ Other (Sp	ecify <b>residence</b>
ing Ph	ü	27. Manner of Deat 1 ☐ Matural	5 Pending	28a. Date of Inju (Month, Da	ury 2 ay, Year) 2	8b. Time Injur	e of 28c. Injur V Worl	y at k?	28d. Describe			
ttend death stor: / the fi	icati	2 ☐ Accident 3 ☐ Suicide	investigati 6		ium. At hom	o form		Yes 2 □No	OOF Leasting	/011		
l or A after Direc 3 in by	Certification: To	4 Homicide	determine	building, ei	tc. (Specify)	ie, iaimi,	street, factory, office		City or To			Rural Route Number,
spita hours ineral y filled		29a. Certifier	1 Certifying	Physiclan: To the best	of my know	edge, de	eath occurred at the ti	me, date and place	, and due to th	e cause(:	s) and manner	as stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2  Medical Ex	aminer: On the basis of and manner st	of examination tated.	on and/o	r investigation, in my o	pinion, death occu	rred at the time	, date an	nd place, and du	e to the cause(s)
Voith Con	Σ	29b. Signature and	I title of certifier	\	$\cap$		29c. Licens			29d. Da	ate signed (Mor	nth, Day, Year)
		- K	X X	- 1	X			7123	7	4	10/01	
10		30. Name and	ress of person wh	o completed cause of o	death (Item 2	23a) (Typ	pe, Print)	20	,tus	+17-	- N	-071121
Sta	e	31. Date filed (Mon			rar's Signatu	re	31	1-61	3 1 3		1	Y
Registra		A	PR 172	008 Been	U K	1	acaste s					
HMH 17 Rev 1/20	nn1			67		1		<del></del>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔠 🕕 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Apri 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt Ton iture ( are more 8. Date of Birth
(Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 233-12-1267 Usual Residence of Decedent Director RGINIA permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 dres 2 No Director MURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VIINING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Nymber, City or Town, State, Zip Code) NEPHEN 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 10 PREDAILIN 21. Signature of uneral service Licens 23a. Part 1. F er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedine cause (Final **Physician** graioVasci 569 /Medical resulting in death) Due to (or as a consequence of) Examiner ementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and as your continuous cause). Due to (or as a consequence of Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy performe 1☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 🗌 No Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier Nacem Name and address of person who completed cause of death (Item 23a) (Type, Print) erz 32. Registra State Registrar

08-02846 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marlin Albert Kinna State of Maryland / Department of Health and Mental Hygiene 2008 12539 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner 1919 hrs April 8, 2008 MARLIN ALBERT KINNA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Director 214-34-0210 1 X M 77 27. 1931 Country) 2 F Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Prince George's Laurel Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8719 Graystone Lane 20708 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Married Yes 9 f Yes, Give Year 3 Widowed 4 XX Divorced 1 Yes 2 XXNo specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Baltimore, MD 21215-0036 D.O.D. Chemical Engineer permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other th Injury or other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Oscar Kinna Be Ruth Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) MaryAnn Carlson daughter 1202 Adams Court Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State West Arundel Crem. 4/26/2008 Odenton, Maryland 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed d. Physician/Medical X UNPENDED attending physician or use as the burial AMENDED 11,27,28a-f, perME, g879 5/27/08 TT Box 68760 IF FEMALE: 23c, If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ģ Records, P. 1 Yes 2 ✓ No 3 Probably 4 Unknown Pelvic fractures Completed certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 1 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other<sub>4</sub> 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 27. Manner of Death 28a, Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 Natural 1 Yes 2 YNo 5 Pending driver in motor vehicle accident March 30, 2008 2:00 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Sulcide Could not be E/B Cherry Lane & Rt. 1 Laurel, MD determined (Specify) roadway Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🕡 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 12, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 🕰. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 April 15, **Physician** 6:30 AM Mary Kritz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3300 Summit Avenue Parkville 8. Date of Birth (Month, Day, Year) August 31, 1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 X F Maryland 219-32-3930 90 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 1416 Stengel Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 years Assembly Line Worker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Snell Margaret Boulder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 Yorkway, Dundalk, Maryland William Buckheit son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 19, 2008 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature of Furleral Service Licensee, 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, r complications that caused the deat of o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Heart Disease 6 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trans and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical JE FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6XXP ther (Specify) Grand caughter 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 Harford Road, Baltimore, Maryland
32. Registrar's Signature Dr. Mchammad Rahnama 31. Date filed (Month, Day, Year) State

Registrar

2008

**APR 17** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician		i-For State Registrar	•	cate of Death	iu ivieritai r		g. No. 2	00	8 1254
	1	1. Decedent's Name (First, Middle,Last)				Date of Deat     Month	h Dav Ye		3. Time of Death
ledical Examine		James LeRoy Kappes		- r		April 14, 2	800		1648 hrs
,		4a. Facility Name (if not institution, give street and number Johns Hopkins Bayview Medical Center	)	Baltimore	r Location of Dea	tn	4c. County	or Death	
Funeral	7		ge (In yrs. last bi	irthday) If Under 1 Ye	ar If Under 24H	rs. 8. Date of Birt	th (MM/DD/YYY		
Director	-	217–18–1710 1XM 2 F	8	Months Da	ys Hours M	october	6,1923	Foreign Cou	ntry)Maryland
amy		10a. State 10b. County	10c. City, Tow	n or Location					10d. Inside City Limits
Maryland 28a-f show 1 at once	5	Maryland Baltimore		Dundalk				ŀ	1 Yes 2 X No
the Maryland a or 28a-f sho tified at once		10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Count	try?
th the 133 or 150 in the 150 in t		7525 Durwood Road		21222			USA		
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Manelal Hygeria and an antural", or items 23a or 28a-f she wit. If items 77 is marked other than "matural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Re Commissed by Firmeral Director	Inuleic			13. Was Decedent of H If Yes, specify Cuba	n, Mexican, Puer		Whit	te, etc.	an Indian, Black,
rs after ural", miner	⋧┞	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade col	mnleted) 16a	1 Yes 2 X N		f work done	Specify: 16b. Kind of B	Whit	
2 hours af "natural" L'Examina	- 1	Elementary/Secondary (0-12) College (1-4 or		during most of working lif			TOD. TAING OF D	usiness/in	ruusii y
5-0036 led within 72 hours a Hygiene. lother than "natura the Medical Exami		9 years		Welder			Stee	L	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)			18.Mother's Nan	ne (First, Middle, M	Maiden Surname	e)	
2121 hould be fill and Mental I is marked utic event,		Le Roy V. Kappes  19a. Informant's Name/Relationship (Type, Print )	1	9b. Mailing Address (Stre		eth Kavar		up State	Zin Code)
e, MD 21215-003 Land 2 should be filed within Health and Mental Hygiene. Tiem 27 is marked other tier Traumatic event, the Med		Bernice Kappes Wife		7525 Durwood					Zip Code)
e, MC 1 and 2 st Health an item 27	ľ	20a. Method of Disposition	20b. Place	e of Disposition (Name of c		pate 19,	20c. Location		Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 XCremation 3 Removal from St 4 Donation 5 Other Specify:	Bayvi	atory or other place) .ew Crematory		008	Baltimo	ore C	ity, MD.
Baltil permit. Departm Importa injury o	t	21. Signature of Funeral Service Licensee	111	22. Name and Addre			Dundal	lb D	λ
		Come Come	Ely	22. Name and Addre Connelly 7110 Sol	lers poi	int Road,	Dunda	lk, MD	21222
Physician Medical		23a. Part I. Enter the disease for complications that caused failure. List only one cause on each line.	0		g, such as cardiad	or respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
vaminer	Ì	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Due to (or as a constant)		ular Disease				_	Death
	1	Sequentially list conditions, b	equente or).						
i i		if any, leading to immediate Due to (or as a cons	equence of):					.53	
uted ransit Examiner	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence of):						
60, ate be executed bhysician and bund - transit	<u> </u>	d				-			
00, te be execut ysician and burial - tra		UNPENDED AMENDED							
	≥ I.	IF FEMALE: 23c. If yes, outco	me of pregnanc	y Fetal death 3	Ectopic preg	nancy	23d. Date of Month	•	ay Year
box 687.  The death certification of the attending probe for use as the physician.	2	past 12 months?  4 Pregnant a	t time of death	5 Other (Specify)					li li
Be e dea	ř.	9 Olikilowii	16 6 4 - 4 4 15						
- £ > 5 0	-,	art in Other significant conditions contributing to dea		ing in the underlying cause	given in Part I	23e Did to	hacco use con	ribute to t	he cause of death?
P.O. s that the gened by e detach		Lung Disease	tn but not resulti	ing in the underlying cause	given in Part I.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			he cause of death? ably 4  Unknown
ds, P.O. equires that the een signed by ould be detach		Lung Disease	th but not resulti	ing in the underlying cause	given in Part I.	1 Yes	an 24b.	Prob	ably 4 Unknown
e law requires that the e has been signed by ge 2 should be detach		Lung Disease	th but not result	ing in the underlying cause	given in Part I.	1 Yes  24a. Was autop perfo	an 24b.	Were aut prior to co death?	ably 4 Unknown  opsy findings available ompletion of cause of
I Records, P.O.  II: The law requires that the tificate has been signed by or, page 2 should be detach.	Completed		th but not resulti			1 Yes	an 24b.	Were aut	ably 4 Unknown  opsy findings available ompletion of cause of
Vital Records, P.O. ysician: The law requires that the lins certificate has been signed by director, page 2 should be detach on Re Committed by P.	pe completed	25. Was case referred to medical examiner? [Hospital: 4 ] legent			ce of Death (Chec	1 Yes  24a. Was autop perfo 1 Yes  k only one)	an 24b.	Were aut prior to co death?	ably 4 Unknown  opsy findings available ompletion of cause of s 2 No
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach in: To Re Committed by P.	lo pe completen	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpati 27. Manner of Death  28a. Date of Inju	ent 2 <b>✓</b> ER/0	26.Plat Outpatient 3 DOA	ce of Death (Chec	1 Yes  24a. Was autop 1 Yes  k only one)  sing Home 5	an sy rmed?	Were aut prior to co death?	ably 4 Unknown  opsy findings available ompletion of cause of s 2 No
sion of Vital Records, P.O. death.  After this certificate has been signed by the funeral director, page 2 should be detach.  After the Recommleted by P. D. Sarion: To Re Commleted by P.	lo pe completen	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpati 27. Manner of Death	ent 2 ✔ ER/(	26.Plac Outpatient 3 DOA  D. Time of Injury 28c. In	oe of Death (Chec Other 4 Nurs urry at Work? Yes 2 No	1 Yes  24a. Was autor perfo 1 Yes  k only one)  sing Home 5 28d. Describe	an 24b. ssy rmed? 2 No 3	Were autoprior to condeath?  1 Yes  Others	ably 4 Vunknown  opsy findings available ompletion of cause of s 2 No
Division of Vital Records, P.O. and a steading Physician: The law requires that the attended of the law requires that the Director: After this certificate has been signed by od in by the funeral director, page 2 should be detach	lo pe completen	25. Was case referred to medical examiner?  1  Yes	ent 2 ✔ ER/(	26 Plat Outpatient 3 DOA  D. Time of Injury 28c. In	oe of Death (Chec Other 4 Nurs urry at Work? Yes 2 No	1 Yes  24a. Was autor perfo 1 Yes  k only one)  sing Home 5 28d. Describe	an 24b. ssy rmed? 2  No 3 Residence 6 how injury occur	Were autoprior to condeath?  1 Yes  Others	ably 4 Unknown  opsy findings available ompletion of cause of s 2 No
Division of Vital Records, P.O. ospital or Attending Physician: The law requires that the hours after death.  uneral Director: After this certificate has been signed by ly filled in by the funeral director, page 2 should be detach.	Certification, 10 be completed	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending 2  Accident Investigation 3  Suicide 6 Could not be determined (Specify)	ent 2 V ER/0 ury Year) 28b njury - At home,	26. Plat Outpatient 3 DOA  D. Time of Injury 28c. In farm, street, factory, office	other Work?  Yes 2 No building, etc.	24a. Was autop perfo 1 Yes  k only one)  28d. Describe 28f. Location (sor Town, S	an 24b. ssy rmed? 2  No 3 Residence 6 how injury occur Street and Numitate)	Were aut prior to co death?  1  Ye  Other:	ably 4 Unknown opsy findings available ompletion of cause of s 2 No  ral Route Number, City
Division of Vital Records, P.C. spital or Attending Physician: The law requires that hours after death.  neral Director: After this certificate has been signed!  y filled in by the funeral director, page 2 should be deta  Certification: To Re Committed by	Certification, 10 be completed	25. Was case referred to medical examiner?  1	ent 2 V ER/G	26. Plat  Outpatient 3 DOA  D. Time of Injury 28c. In  farm, street, factory, office	other Nursury at Work? Yes 2 No building, etc.	24a. Was autop perfo 1 Yes  k only one)  28d. Describe    28f. Location (sor Town, Sound due to the caus	an 24b. ssy rmed? 2 No 3 Residence 6 how injury occur Street and Numi	Were aut prior to co death?  1 Ye  Others  Others	ably 4 Unknown opsy findings available ompletion of cause of s 2 No  ral Route Number, City ad.
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.  Medical Certification: To Re Commisted by P.	Certification, 10 be completed	25. Was case referred to medical examiner?  1 Ves 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Day; 28a. Date of In (Month, Day; 3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only 1 Certifying Physician; To the best of not contained (Check only 1 Certifying Physician; To the best of not contained (Specify)	ent 2 V ER/G	26.Plat Outpatient 3 DOA  D. Time of Injury 28c. In 1 farm, street, factory, office eath occurred at the time, r investigation, in my opinion	other Nursury at Work? Yes 2 No building, etc.	24a. Was autop perfo 1 Yes  k only one)  28d. Describe    28f. Location (sor Town, Sound due to the caus	an sy 24b.  Residence 6 how injury occur  Street and Num  tate)	Were aut prior to cu death?  1 Ye  Other:  or red  ber or Run  er as state due to the	ably 4 Unknown  opsy findings available ompletion of cause of s 2 No  ral Route Number, City  ad.
To To Son	Certification, 10 be completed	25. Was case referred to medical examiner?  1  Yes	ent 2 V ER/G	26. Plat Outpatient 3 DOA  D. Time of Injury 28c. In 1 farm, street, factory, office leath occurred at the time, r investigation, in my opinic	Other Work?  Yes 2 No building, etc.  date and place, alon, death occurred	24a. Was autop perfo 1 Yes  k only one)  28d. Describe    28f. Location (sor Town, Sound due to the caus	an sy 24b.  Residence 6 how injury occur  Street and Num  tate)	Were aut prior to co death?  1 Yes  Other: rred  or as state due to the med (Month)	ably 4  Unknown  opsy findings available ompletion of cause of  s 2  No  ral Route Number, City  add. a cause(s)
To To See Market	medical Celtification, 10 be Completed	25. Was case referred to medical examiner?  1  Yes	ent 2 ER/( ury Year) 28b  njury - At home, ny knowledge, dr y hination and/or death (Item 23a)	26. Plat Outpatient 3 DOA  D. Time of Injury 28c. In 1 farm, street, factory, office leath occurred at the time, r investigation, in my opinic 29c. Licer O.C	other Work?  Yes 2 No  building, etc.  date and place, alon, death occurred as a number  S.M.E.	24a. Was autop performed to the cause of the time, date	an 24b. ssy 2 No 3 Residence 6 how injury occur Street and Num state) se(s) and manner and place, and 29d. Date sig	Were aut prior to co death?  1 Yes  Other: rred  or as state due to the med (Month)	ably 4  Unknown  opsy findings available ompletion of cause of  s 2  No  ral Route Number, City  add. a cause(s)
To To Son	incural Certification, 10 be Completed	25. Was case referred to medical examiner?  1 V Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of more) 2 Medical Examiner on the basis of examin	ent 2 ER/( ury Year) 28b  njury - At home, ny knowledge, dr y hination and/or death (Item 23a)	26.Plat Outpatient 3 DOA D. Time of Injury 28c. In 1 farm, street, factory, office leath occurred at the time, r investigation, in my opinion 29c. Licer O.C	other Work?  Yes 2 No  building, etc.  date and place, alon, death occurred as a number  S.M.E.	24a. Was autop performed to the cause of the time, date	an 24b. ssy 2 No 3 Residence 6 how injury occur Street and Num state) se(s) and manner and place, and 29d. Date sig	Were aut prior to co death?  1 Yes  Other: rred  or as state due to the med (Month)	ably 4  Unknown  opsy findings available ompletion of cause of  s 2  No  ral Route Number, City  add. a cause(s)

,	,		For State of Maryland / Dep State Registrar  State of Maryland / Dep	artment of Health and I <i>rtificate of Death</i>		giene <sub>Reg. No.</sub> 2008	1 12542
t			Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
	Physici /Medic		Janie Mae Gilmore Logan		April	11 2008	1730 M
i	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	th
_			Washington Adventist Hospital	Takoma Park		Montgomer	
ú	Funeral Director		5. Social Security Number  246-16-3718  6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 91 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birl (Month, Da 10-5-19	v. Year) C	thplace (State or Foreign ountry)
	aryland show d at	_	Usual Residence of Decedent  10a, State  10b. County  10c. City, Town or L				10d. Inside City Limits XXYes 2 □ No
	he Ma 18a-f	Director	MD Prince Georges Riverdal			10 000	
	with the	ä	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	eath	Funeral	5418 Kenilworth Terrace #1           11. Marital Status         12. Was Decedent Ever in U.S.         13.	20737 Was Decedent of Hispanic Origin? (St	necify Yes or No	USA - 14. Race - Ame	erican Indian.
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	à S	1  Never Married 2 Married 1  Yes 2 No If Yes, 2 Yes are or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes ※☐ No Specify:	o Rican, etc.)	Black, White Specify Bla	te, etc.
2-0-1	nin 72 ho r "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation hind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business	/Industry
7	d with giene er tha the l	mo.	2 yrs Nurse			Private Du	ty
2	al Hy I othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
<u>8</u>	ould k Ment arkec atic e	2	Will Gilmore	Hannah J			
<u>a</u>	2 short n and rismi			ng Address (Street and Number or Ru			•
ב ע	1 and Health Sm 27 ther t		Norma Jean Parker/Granddaughter 5418 20a. Method of Disposition   20b. Place of Disp		#1 Rive	erdale, MD  20c. Location - City or	
Dallinor	Eant: If its		4 Donation 5 Other (Specify)		-2008	Washington,	DC
00	permit Depar Impor any In			2. Name and Address of FacilityMar 217 9th St NW Wa	shall's shington		
	100		23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  EPTIC  a.	SHOCK DINTESTIMALI			Onset and Death
9	/Medical Examiner		Due to (or as a consequence of):	LITEST: NAI	Scilen	4.30	
		er		D /NIWIIIIC I	SCHEM	1114	
/	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ś	exec an an rial-tr	Еха	resulting in death) Last  Due to (or as a consequence of):				
00/00	ficate be executed physician and is the burial-transit	edical Examiner	d				
	# D #		IF FEMALE:				
.C. DO.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
٦, ٦	uires that signed b d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
5	w req	lete			24a. Was	an 24b. Were a	utopsy findings available
מם ומו	Attending Physician: The laver death. Sector: After this certificate has by the funeral director, page 2 by the funeral director, page 2.	Completed	25. Was case referred to medical		autor perfo 1∐ Yes	osy prior to ormed? death? 2 M No 1 ☐ Yes	completion of cause of
>	/sicia s cert	o Be	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Dea		one) dence 6 □Other (Spe	nciful
5	g Ph ter thi	ü	27. Manner of Death 28a. Date of Injury 28b. Time of			how injury occurred	ony)
2	endin ath. or: Aff	atio	2 Accident investigation	M 1 Yes 2 No			
2	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To ti Withii To ti comp	Ž	29b. Signature and title of certifier	29c, License number		29d. Date signed (Mon	th, Day, Year)
1			· MUF-M	66771		4/15/	08
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, 7400 CARRULL A VELVE, TAKOMA HARK MD 20912	FINGEL GALE	na-Si	ANTIAGO, M	1)
is.	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 7 2008	dist			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d State of Maryland / Department of Health and Mental Hygiene Per Phy G878 4/17/08 JH Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:44 P 2008 Robert Dale Lycliter April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs 232-62-1188 Feb. 24, 1940 West Virginia Director 68 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show Idical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 USA 1840 Eloise Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Maryland 21215-0036 þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Automobile Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Opal Alice Phillips 9 Ila L. Lycliter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernadette P. Lycliter / Wife 1840 Eloise Lane, Edgewood, MD 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition P Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Important; If any injury o 4-16-08 Baltimore, Maryland Gardens of Faith Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. re of Fun 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Electro Magnetic Physician 30 min /Medical Due to (or as a consequence of): **Examiner** Lachemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Congestive or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. It 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 130053720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinnarajah Raguraj M.D. 6025. Atwood Rd., #100 Bel Air, mo 21014

DHMH 17 Rev 1/2001

Registrar

APR 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 13 dd PM Lightsex, Jr 2008 15 PCI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Northwest Hospital center RUNDAllstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/09/1963 Birthplace (State or Foreign Country)
\_\_\_ 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 220-80-6248 44 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2107 Herbert St. 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvements Hygiene, Electrical Alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris McRae Guy Lightsey, SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1929 W. Mulberry St., Baltimore, MD 21223 Antoine Davis / Son item 27 i other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
W Arundel Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/17/2008 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Funeral Service Licensee MO1452 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): HIV infection Examiner Bud State I-Due to [or as a constituence of): Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed anding physician and use as the burial-transi Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy has 2 No 2 No certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? After 1 Matural 5 ☐ Pending investigation spital or Attendii lours after death. neral Director: A riilled in by the fu 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00065425

5

State Registrar 31. Date filed (Month, Day, Year)

APR 1 7 2008

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Court RA: Randallstown, MD 21133

			For State Registrar	State of Marylan		artment of He r <i>tificate of D</i>				008	) 1	254
	13 =		Decedent's Name (First, Middle, La	st)				2. Date of De	eath			e of Death
_	Physici /Medic		Charlotte		Mill	er		April	15, <sup>2008</sup>	Year	2:15	5 P M
	Examin	er	4a. Facility Name (If not institution, giv	,		4b. City, Town, or I			4c. County			
_			6909 North Point  5. Social Security Number 6. S		last hirthday)		WS Point If Under 24 Hrs.	8. Date of Bir	Balti			te or Foreign
ð.	Funeral Director		213-28-5851	□м 2 <b>X</b> 3 F 7.		Months Days	Hours Min.	September	** 18, 1932	Mar	ylanc	_
	yland low at		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				1	10d. Inside	e City Limits
	e Mar	ctor	Maryland Baltimo	re Si	parrow	s Point					1 □ Y	′es 2X∑No
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	Nhat Cou	ntry?	
	s 23a		6909 North Point	Road  12. Was Decedent Ever in U.	e   10 1	212		oifu Voc or N	USA 14 Bac	e - Ameri	can Indian,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 🍇 No	sparific Origin? (Sparific Origin? (Sparify:	Rican, etc.)	Blac	ok, White, Whi	, etc.	ŀ
5-0	72 h "natu dical	etec	15. Decedent's E	ducation ade completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	tion uring most of worki	ing	16b. Kind of B	usiness/In	idustry	
121	within ene. than '	Completed	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)		okkeeper			Crane	Ront	al Co	າຫາລານ
d 2	filed withi Hygiene. other than ent, the M	Be Co	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle			ar a	Miparry
<u>la</u> n	ald be dental rked o	To B	Charles Morrison				Margaret	Thomp	son			
ary	12 should be filed v n and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship (	**		ng Address (Street ar				, ,	,	24.0
	l and dealth		Vincent B. Miller			North Poir		Sparro				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other try once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Fernation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Inemoval from State		sition (Name of matory or other place Crematory	April 200		20c. Location  Baltimor	•		
3alti	permit. Departri Importa any Inju		21. Signature of Funeral Service Lice	nsegy	7	Name and Address Onnelly Fu 110 Soller			Dundalk,	P.A.	<u> </u>	<u>, ur</u>
500	GD = 6 0		23a Part1 Enter the disease or com	unlications that caused the death	The not ent	110 Soller	rs Point	Road,	Dundalk,	Md.	21222 Approxir	
_ 1	Dharaisian		23a. Part1. Enter the diseale or com shock, or heart failure. ist only Immediate Cause (Final	one cause on each line.	1	er die mode or dying	, such as cardiac t	or respiratory a	irrest,		Interval I Onset ar	Between nd Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	1 10/0>	10				111	NON / M
_	Examiner			CANCER	CAM	T TONS	PO CHAM	ignix			1110	WTH
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	1 - 1	-	1				
W	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
68760, M	e be executed sician and burial-transit	sal E		Due to (or as a consequ	derice oi).							
89	tificate b ig physic as the b	ledical										
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 D No 9 ☐ Unknow	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	∃Ectopic pregnancy ∃ Other <i>(specify)</i>				te of deliv	very Day	Year
۳.	s that ined by detail	by Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giver	n in Part I.	23e. Did	tobacco use con	tribute to t	the cause	of death?
rds	equires en sig oufd be	ed b	Dysp ItABI.	A				1)	Yes 2 □ No	3 ☐ Prol	bably 4	□Unknown
Division or Vital Records, P.O.	The law re ate has be page 2 sho	Completed	CHAINIC ,	ASPINATION I	Neun	NONIA		24a. Was auto perf 1∐ Yes	ormed?	prior to co death?	opsy findin ompletion o	ngs available of cause of
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Lincoltal			26. Place of Death		one)			
0	ding Physician: The	- To	1 Yes 2 De 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatier 28b. Time o		4 Li Nursing Ao		idence 6 Oth		fy)	
on	th. th. After tunera	tion	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work'	? ′es 2 □ No	Edd. Describe	now injury occur	red		
VISi	Atter r deal ector by the	ifica	3 Suicide 6 Could not b	e Rose Blace of injury. At he	me, farm, str	eet, factory, office			Street and Numl	er or Rur	al Route N	Vumber,
Ö	Ital or rs afte rai Dir	Certification:	4 Direction	building, etc. (Specin)	,, 			City of To	wn, State)			
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	edical		nysiclan: To the best of my kno miner: On the basis of examina and manner stated.								se(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month,	Day, Yea	r)
			De Nota	und mo		12813	3		4/161	108		
	6		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print) RAZ	nmore	m	2170	y		
	Sta		31. Date filed (Month, Day, Year) APR 1 7 20	3 Registrar's Signa	ture	2000 6						
	Registr	ar	WIN TI 50	July July Si	MAGA	The state of the s						

Registrar DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Cei	rtificate of i	Death		Reg. N	o	2 6
e.		1. Decedent's Name (First, Middle, Las	st)				2. Date of D		- V	3. Time of Death
Physi		Robert Devon M	cCann				April	12	2008	2:04 PM
/Med Exam	dical	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De		4	c. County of Death	
LAGII		Baltimore Washington	_	00	Glen	Burn	0		Anne An	undel
Funera	1	5. Social Security Number 6. S		ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of B	irth	9. Birth	place (State or Foreign
Directo		185-26-8057	<b>X</b> M 2□F 72	Yrs.	Months Days	Hours Mi				intry) nsy <b>1</b> vania
~		Usual Residence of Decedent					11.009	,		
ylan		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
Mar fled	햐	Maryland Anne	Arunde1	Gle	n Burnie					1 ☐ Yes 🗶 📉 No
r 282 noti	Director	10e. Street and Number		010	10f. Zip Code			10g. C	itizen of What Cou	intry?
3a o		500 Kintop Road			21061	L		Un:	ited Stat	ces
ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or N	10-	14. Race - Amer	
after or ite		1 ☐ Never Married 🍇 🛣 Married	tx XYes 2 □ No				erto Hican, etc.)		Black, White	
uns a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 19	02	1 ☐ Yes 2½ ∏ No	Specify:			Specify: V	White
be filed within 72 hours after death with the Maryland rat Hygiene.  vial Hygiene.  do other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	dent's Usual Occup	ation	vaskina	16b.	Kind of Business/I	ndustry
e. an "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	dring most of v d)	vorking			
filed within Hygiene. other than '	ő	12	J- ( ,	Mana	ger			A1	utomotive	Store
e file c	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middl	le, Maide	n Surname)	
Aer to	10	Robert Eugene Mc	Cann			Lillia	an Irene	Kie	per	
gges 1 and 2 should be filed within nt of Health and Mer tal Hygiene. If frem 27 is marked other than " or other traumatic -vent, the Mer	'	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Num	ber, City	or Town, State, Z	p Code)
alth a		Mrs. Phyllis McCar	nn / Wife	500	Kintop Ro	l. Glen	Burnie.	MD :	21061	
item othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	20)	Date		Location - City or T	own, State
Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Inemoval from State		e Vet. Ce	ADI	il 16,	Cro	wnsville	MD
	pi li	21. Signatur Funeral Service Licer		22	2. Name and Addre	ss of Facility		1	•	
permit. Departi Importi any Inj	3	I live & I ha	w	\{ \frac{1}{4}	Name and Addre irkley-Ru 2I Crain	Hwy S	uneral I E Glen	Home Buri	nie, MD 2	21061
- 4		23a. Part1. Enter the disease, or com shock, or heart failure. List only	oligations that caused the death							Approximate
Division		shock, or heart failure. List only Immediate Cause (Final	1 120							Interval Between Onset and Death
Physicia: /Medica	_	disease or condition resulting in death)	a. Due to or as a consequ	Shock						
Examine			72	75		^				
	<u>.</u>	Sequentially list conditions,	b. DACTE A		eumoni	7				
ted usit	Ë	Cause (Disease or injury		,						
xecu and	Examine	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):					<del></del>	
certificate be executed ding physician and se as the burial-transit										
ate the	edical		d						-	
certific nding p	N.	IF FEMALE:	23c. If yes, outcome pf pregna	ncv					004 B-t( 4-15	
atten for u		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		Ì	23d. Date of deliver Month	Day Year
at the de by the a	Physicial	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	aui JL						
The law requires that the death the has been signed by the atternage 2 should be detached for u		Part II. Other significant conditions of	ontributing to death but not resu	ıltina in the uı	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
signe	þ				, , , , , , , , , , , , , , , , , , , ,					babiy 4 □Unknown
w requir been si should	Completed						- 4		7	— — — — — — — — — — — — — — — — — — —
e law nas b	를						24a. Wa – aut	opsy	prior to c	opsy findings available ompletion of cause of
	Ö						per 1∐ Yes	formed? 2€3N	death? lo 1 □ Yes	2□ No
Attending Physician: The reach.  ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?					eath (Check only	one)		
चैं <u>दे</u>	2	1 ☐ Yes 2 [StNo	Hospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Oth	er: 4 ☐ Nursing	Home 5□Re	sidence	6 ☐Other (Spec	ify)
ng Ph Ifter th		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur Wor	y at k?	28d. Describe	e how inj	ury occurred	
endi sath. or: A he fu	atic	2 Accident investigation				Yes 2 ☐ No				
r Att er de irect	ţį	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify		eet, factory, office		28f. Location City or T	(Street a	and Number or Rui te)	ral Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:								<u> </u>	
hou ner		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examination	wledge, deatl	h occurred at the tir	me, date and pla	ace, and due to th	e cause(	s) and manner as	stated.
the H in 24 in E F	Medical	one)	and manner stated.	and/or III			at the time	o, uale a	na piace, allu uue	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	. 4		29c. Licens			29d. D	ate signed (Month	, Day, Year)
		Henry tr	on with		002	7415		An	ul 12,	200 8
V.		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)					
. Y.		Henry Fran	cis MD. BAI	T'MOCK	: WAShin	ton N	reducal a	Cent	-01	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 20 56M 2008 William 12 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor MD Hookins Medical Saltmore INSTITUTE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 08/22/1945 Social Security Number Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MD 215-42-1518 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1516 LANCASTER ST., , APT. 2C 21231 "natural", or items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the Mones. ATTORNEY AT LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MONFRIED LOUIS **EDITH** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MONFRIED / WIFE 1516 LANCASTER ST., APT. 2C, BALTIMORE, MD 21231 20b. Place of Disposition (Name of Mo CANERA BRAHLIM (ADATH YESHURUN) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SESHURUN) 04/14/2008 ROSEDALE, 22. Name and Address of Facility SOL LEVINSON & BROS., 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Neu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / ould not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral [ rtf pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Welfe Street Baltmore MD 20287 Conco 600 REDERIC K Month, Day, Year) APR 1 7 2008 Registrar's Signature 31. Date filed (Month, Day, State Registrar

			1 100						c All Oopic		•	
			For	State of Ma	aryland	/ Depa	artment of I	Health an	id Mental H	ygiene		: (1) (10)
			1 = State Registrar			Cei	rtificate of	Death		Reg. No	2008	12548
		90	1. Decedent's Name (First, Middle	e, Last)			· -		2. Date of D			3. Time of Death
	Physici		PAUL J.	NEWLON					Month	1 3		15 19 PM
	/Medic		4a. Facility Name (If not institution	a give street and number)			4b. City, Town, o	or Location of D	Death		. County of Death	
7	Examin	ier	FRANKLIN SQU		ni co	OTOS		sedal				more
	F		5. Social Security Number		e (In yrs. la		If Under 1 Year	-	Hrs 8 Date of B	irth	0 Diet	place (State or Foreign
	Funeral Director		216 40 1904	1 <b>X</b> M 2 □ F	65	Yrs.	Months Days	Hours	Min. (Month, E	ay, Year) <b>/ 1 Q /</b> 1	3 MEST	r VIRGINI
Н			Usual Residence of Decedent						2/19/	124	J WID.	VINGINI
	lanc ow at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mar) fsh ied	호	MD	1/a		BAT	TIMORE					1 <b>X</b> Yes 2□No
	the 28a notif	Director	10e. Street and Number	• /			10f. Zip Code			10g. Cit	tizen of What Cor	untry?
	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ā	935 SPANGLER	V A TAT O				212	0.5		SA	,
	eath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13	Was Decedent of I				14. Race - Amer	ican Indian
	Iten Iten	ä	1 □ Never Married 2 □ Marri	Armed Forces?		.   10.	If Yes, specify Cub	oan, Mexican, F	? (Specify Yes or Nouerto Rican, etc.)		Black, White	
ည	rs af	by	3 Widowed 4 □ Divorced	ied 1 ☐ Yes 2 ☒ ↑ If Yes, Give Year or Dates:			1□Yes 🌠 No	Specify:			Specify: V	VHITE
2-0036	72 hours after 'natural', or Ite dical Examine	pa			- 4	16a. Dece	dent's Usual Occu	pation		16h K	(ind of Business/I	ndustry
Š	in 72 i "na ledio	Set	15. Decedent (Specify only highes		111	(Give life.	kind of work done DO NOT use retire	during most of	f working			
7	within iene. than " the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ABOR	•		BA.	LTIMORE	CTTV
D	filed Hygi ther int, t		17. Father's Name (First, Middle,	Last)			IIBOK	18. Mother's	Name (First, Middi			CIII
and		Be c	HARRY L.	NEWLON				HAZE			SMITH	
Š	hould d Me mark matic	유	19a. Informant's Name/Relations			10h Mailir	an Address (Street		or Rural Route Num			in Cadal
<u> </u>	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		ANN HOLEWINSK		,					•		
e,	l and dealt		20a. Method of Disposition	I / DAUGHTE					OAD, BAI		ORE, ML ocation - City or	
0	Pages nent of I int: If Ite		1 ☑ Burial 2 ☐ Cremation	3 Removal from State	1		sition (Name of matory or other pla				•	
	tmer tant:		4 Donation 5 Other (S		BLU		T CEMET				FTON, W	
Daltimol	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service	Livensee		22	2. Name and Addre	ess of Facility	CVACH/F	OSE	DALE FU	NERAL HON
_	90 E 8 9		6			į. I	ZII CHE	SACO	AVE BALT	TMO.	RE, MD	21237
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death.	Do not ent	er the mode of dyi	ing, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Sho					Onset and Death
	/Medical		resulting in death)	Due to (or as	a con seguire	ance of).						
	Examiner			Cono	DET	1110	Hec	art	Failu rome	00		
b	4 - 5	er	Sequentially list conditions, in any, leading to in residue cause. Enter Underlying Cause (Disease or injury that initiated events	Dun to (or se	a conseque	nos offi				See		
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury	ACUT	P. C.	ono n	ary	Sund	Com to			
,	exec n an	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):		1	0 771			
20	sicial buri	call										
	physicate physics physics			u								
×	certi nding ise a	Ž.	IF FEMALE:	23c. If yes, outcome	pf pregnan	cy					23d. Date of deli	von/
Š	atter for u	sician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal o	death 3	Ectopic pregnand Other (specify)	у			Month	Day Year
j	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time of dea	atii J						
7.	that t	Phys	Part II. Other significant condition	ons contributing to death be	ut not result	ing in the u	nderlying cause gi	ven in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
'n	siclan: The law requires that the death certifica certificate has been signed by the attending phrector, page 2 should be detached for use as the	by						von in r dit i.		_		obably 4 □Unknown
Solds	requi	Completed							-	1163 2		
S S	law as b	ple							24a. Wa	s an opsy	24b. Were au	topsy findings available completion of cause of
	The ate h page	μO							per 1□ Yes	formed?	_ death?	2 □ No
ם ב	lan: rtific	മ	25. Was case referred to medical					26. Place of	Death (Check only			
	Attending Physiclan: or death. rector: After this certific by the funeral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2□E	R/Outpatier	nt 3 DOA Oti	her: 4 🗆 Nursi	ng Home 5 □ Re	sidence	6 □Other (Spec	cifv)
5	g Ph er th		27. Manner of Death	28a. Date of Inju (Month, Day	ry 2	28b. Time o Injury	f 28c. Inju Wo		28d. Describe			
NISIOE I	Attending r death. ector: After by the fune	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	9	y real)	Highly		]Yes 2 ☐ No				
2	I or Attend after death Director: /	fice	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined   Zoe. Place of Inju			eet, factory, office		28f. Location	(Street a	nd Number or Ru	ral Route Number,
5	afte afte din b	Certification:	4   Hornicide	building, etc	с. (Specify)				City or I	own, State	θ)	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the t		29a. Certifier 1 CertifyIn	g Physician: To the best	of my know	ledge, deat	h occurred at the t	ime, date and p	place, and due to th	e cause(s	and manner as	stated.
	e Ho 24 h e Fui letely	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basis of and manner sta	f examination	on and/or in	vestigation, in my	opinion, death	occurred at the time	e, date an	d place, and due	to the cause(s)
	vithin o th	Me	29b. Signatury and title of certifier				29c. Licens	se number		29d. Da	ate signed (Month	n, Day, Year)
	PSP0		) ( ) d. 0	MI: MAT	)	UD	RF	2500	00	11	-13 -	2008
	,/		20 Name and address of	LUI OU OCC	ooth /lt-	22a) (Ti				7	-13	
	h		30. Name and address of person	wno completed cause of d	eath (Item 2	23a) (Type,	riini)					ñ

State Registrar

5

NEWLON

DR Carl Middle Ton 9000 FRANKLIN Square Hospital DR Balto Md 21237
31. Date filed Morr, Day, Pear 1008 32. Registrar's Signature

0

State Registrar 31. Date filed (Month, Day, Year)

Kwuma

1124 Mace Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Evenue, Bultimore

MD 21221

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 04 10 04:08 M 2008 Margurite Estelle Peace /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4214 Kenshore Ave If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🔽 F 03 09 Director 88 MD 212-44-4431 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a State ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maxical Examination and he mailtheam 1 Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21215 U.S.A. 927 Bethune Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes Y No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Beauty Salon Cosmologist 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Hilda Johnson Clifford Fagan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Carolyn Shoulders-Daughter 4214 Kenshore Ave, Baltimore, Md 21215 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/17/08 Randallstown, Md 22. Name and Address of Facility
March F/H West of Funeral Service Licenses mal 21215 4300 Wabash Ave, Baltimore, Md Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23 . Part 1. Immediate Cause (Final dise see r condition resulting in death) **Physician** Cardiac Arrest years /Medical Due to (or as a consequence of) **Examiner** 5 Years Diabetes Mellistus, Hypertension Sequentially list conditions, if any, leading to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off: Examiner sician and burial-transit The law requires that the death certificate be executed 2 Years Hyperglycemia, Hypertension Due to (or as a consequence of): P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown Anemia 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ★Yes 2 □ No Be 26. Place of Death (Check onl one Houses Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAHD 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

State

gistrar's Signature

William Christopher Golden, 600 North Wolfe Street, Beltimore, Moryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

			Please	Type or Prin							Legible.	
			For State Registrar	State of Ma	aryiano		arimeni oi rtificate o	Health and f Death	Mental Hy	/giene Reg. No.	2008	12553
385	Physicia	an	1. Decedent's Name (First, Middle, Lac	· ·	Dazza				2. Date of D		2008 <sup>Year</sup>	3. Time of Death 7:30 A M
	/Medic	cal	Delores 4a. Facility Name (If not institution, givi		Rozga	<u> </u>		, or Location of Dea	April	4c.	County of Death	
, 			7526 School Avenu  5. Social Security Number 6. S		o /lo uro l	ast birthday)	Dunc		s. 8. Date of B		Saltimore	place (State or Foreign
	Funeral Director			mex 2XTF 7.Ag	60 60	- /	Months Day			ay, Year) 1, 194	8 North	Carolina
Ī	rland ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation				-	10d. Inside City Limits
	he Man :8a-f sh otified	ector	Maryland Baltim	ore		Dunda	1			40 000		1  Yes 2 1 No
	h with th	al Dir	7526 School Avenue	е			10f. Zip Cod	)   222		Tog. Citi	zen of What Coul USA	ntry ?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 【X Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			Was Decedent of If Yes, specify O 1 ☐ Yes 2 🛣	of Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or Nerto Rican, etc.)	_	14. Race - Americ Black, White, Specify: Whit	etc.
5	n 72 hou "natura	leted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usual Oc	cupation ne during most of w ired)	orking	16b. Ki	nd of Business/In	dustry
7	d within giene. er than the Me	Completed	Elementary/Secondary (0-12) 11 years	College (1-4or 5	5+)		sewife			Own	n Home	
yiana,	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last, Chester Dziennik			-T		Magdal	ame (First, Middl ine Coop	er		
<u>0</u>	nd 2 sh alth and 27 Is m r traum		19a. Informant's Name/Relationship ( Leo D. Rozga	<sub>Type. Print)</sub> Husban	nd			eet and Number or I		-		
ָה ה	ges 1 au t of Hea lf item or othe		20a. Method of Disposition  1 Burial 2 Acremation 3				osition (Name of matory or other		il 19,	20c. Lo	cation - City or T	own, State
altillo	nit. Pag artmeni ortant: Injury e.		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer	ý)	Bay		Cremato: 2. Name and Ad		~ ~ ~	1	imore Ci	
<u> </u>	permi Depar Impor any Ir		Enthony	Conse	lle			ress of Facility Funeral Lers Poin			alk,P.A.	
	Physician	9	23a. Part1. Enter the diseas of com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li	the death ne.		Bound G		ac or respiratory	arrest,	٧	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequ	uence of):						
Q	ped isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
,	be executed cian and ourial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):						
000	tificate Ig physi as the b	ledica		d								
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 型 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	□Ectopic pregna □ Other ( <i>specif</i> y			:	23d. Date of deliv Month	ery Day Year
Colds, T	equires that en signed b ould be deta	by	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	inderlying cause	given in Part I.				the cause of death? bably 4 Unknown
ב	The law re rate has be page 2 sho	Completed							per	s an opsy formed? 2 No	prior to co death?	opsy findings available ompletion of cause of 2 In No
VII	sician: s certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 DOA	Other:	eath (Check only		6 □Other (Speci	(fu)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	27. Manner of Death  1 ♣ Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury	of 28c. I	njury at Vork? Yes 2 No	28d. Describe			
	tal or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At ho tc. <i>(Sp</i> ec <i>if</i> )	ome, farm, st	reet, factory, off	ce	28f. Location City or T	(Street an own, State	d Number or Rur !)	al Route Number,
	he Hospi in 24 hou he Funer pletely fill	Medical		nysician: To the best miner: On the basis o and manner st	of examina							
	Mith To 1	Σ	29b. Signature and title of certifier	0 81-11	du	1/100	101	ense number		4/11	te signed (Month,	Day, Year)
	7		30. Name and address of person who	completed cause of o	death (Item	1 23a) (Type,	Print) EMPI	- Ala f	PALTINA	Md	2/22	4
	Sta Registr		31. Date filed (Month, Day, Year)	39. Registr	rar's Signa	ture	ule)	1				,
-												

			1 - State Registrar		Cert	ificate of D	eath	Re	eg. No. 2 U U O	12331
Ψ •	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  DOVALD RAY	NER			į	2. Date of Death	10 2008	
	Examin		4a. Facility Name (If not institution, give str	reet and number)	1-	4b. City Town, or Lo	ocation of Death	LORE	4c. County of Death Baltimore	
	uneral irector		5. Social Security Number 6. Sex 220–14–5720	7. Age ( <i>in yrs. la</i>	st birthday)_ Yrs.		Hours Min.	3. Date of Birth (Month, Day, une 22,	9. Birth	place (State or Foreign intry)
and	ě 4	0	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Maryl	a-f sho	tor	Maryland Anne Aru	ndel Gle	en Bur	nie				1 ☐ Yes <b>2</b> No
ith the	or 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	intry?
ath w	s 23a nust t	eral	1716 Tieman Drive	2. Was Decedent Ever in U.S	12.14	21061	anio Origina (Cana	ifr Vec or No	United Sta	
be filed within 72 hours after death with the Maryland	ral", or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Status  1 X Never Married 2  Married  3  Widowed 4  Divorced	Armed Forces?  1 ☑ Yes 2 ☐ No WW If Yes, Give Year or Dates:	11	/as Decedent of Hisp Yes, specify Cuban, □ Yes 2☑ No	Mexican, Puerto R	ican, etc.)	Black, White	
hin 72 ho	"natu edical	Completed	15. Decedent's Educe (Specify only highest grade	ation completed)  College (1-4or 5+)	(Give k	ent's Usual Occupati ind of work done du O NOT use retired)	ion ring most of working	g	16b. Kind of Business/l	ndustry
ed wit	rer than	Соп	12		Claim	s Examine			Social Secu	rity
d be fill	ed off	Be	17. Father's Name (First, Middle, Last)  Robert Joseph Ras	ner		'	8. Mother's Name ( Anna Eli		,	
should	important: If item 27 is marked other than any injury or other traumatic event, the Money.	70	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street an			City or Town, State, Z	ip Code)
and 2	n 27 k ner tra		Roberta Vinci / Nie	ece					PA 17532	
ages 1	or off		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State ce.	metery, crem	ition (Name of atory or other place)	i -	14,	20c. Location - City or I	
nit. Pa	ortant Injury e.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral (Serving Ligensee			emetery Name and Address rkley-Rudo	of Facility _		altimore, M	aryland
Den	any In		> Lu Lebe	/		_			ne P.A. urnie, MD 2	1061
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only	ations that caused the death.	Do not ente	r the mode of dying,	such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	Per fova		Livert	-i culi			
	aminer			S E P	2 IS					
, p	±±;	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
xecute	and il-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
e pe e	physician and s the burial-transit		<b>€</b> d.							
ertifica	ing phi e as th	Medical	IF FEMALE:			<u>.</u>				
The law requires that the death certificate be executed	he attending pled for use as t	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of dead of the pregnant at time of	death 3∐	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
that th	been signed by the should be detached		9 ☐ Unknown  Part II. Other significant conditions cont	ributing to death but not result	ting in the un	derlying cause given	ı in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
quires	en sign	Completed by	CONGESTIVE	HEART FA	ITLU	RE		1. <b>⊠</b> Y∈	es 2□No 3□Pro	obably 4 □Unknown
law re	2 2	plet	COLOWARYA	KTERYI	SIC	EASE		24a. Was ar	y prior to c	topsy findings available ompletion of cause of
The	icate h		HCUTERE	ENALF	AI	LURE	2	perform 1⊟ Yes 2	ned? death? 2⊠No 1 ☐ Yes	2□ No
siciar	s certif lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital: 1 <b>⊠</b> înpatient 2 🗆 E	R/Outpatient	Othor	26. Place of Death		e) ence 6 □Other (Spec	nifv)
ng Ph	fter this	n: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury a			ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
tend!	the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	29a Plana of Injury At han	mo form stro		es 2 No	Pf Location (St	reet and Number or Ru	um l Pouto Numbor
ital or A	ral Directed in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify)	)	et, factory, office		City or Towr		nai noute Number,
the Hospital or Attending Physician:	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		cian: To the best of my know er: On the basis of examinati and manner stated.						
To the	To t	×	29b. Signature and title of certifier	DR, GAC	JARI	29c. License	number C	2	9d. Date signed (Montl	n, Day, Year)
	,		20 Name and address of march	onloted cause of death //	M.	D. HAD B	> 00	SDTTA	TRKIL,	Coutil
	V		30. Name and address of person who con OR, ChAGARI J, N	1.D. H	A NO	JER ST	REET	BALT	IMORE !	4021225
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signate					)	

State

Registrar

APR 1 7 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death april Year Oscar Rudoff Day 15 **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick MultiCare Center N/A Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 219-18-6410 XX M 2□ F 87 BAlto, Director May 17,1920 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XXYes 2 □ No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3544 Keswick Road 21211 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**XXX**No Specify: Specify: White 2 3 XVidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Chestnut Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isreal Rudoff MAry Melnikoff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Grice (Daughter) 3544 Keswick Road Balto, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State 4/16/08 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service License 3631 Falls Road Balto, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestive heart failure Years. **Physician** /Medical Due to (or as a consequence of): Hyperstensive cardian asenlar disease **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ renal failure 2☐No 3☐ Probably 4☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has birector, page 2 s 1∐ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D13657 april 15, 2008 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 W-40th STREET, BALTIMORE, ND 21211 MISABELLE THESRESOR 31. Date filed (Month, Day, Year) APR 1 7 2008 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<sup>Day</sup> 2008 **Physician** JAMES ELLERT SCOTT APRIL 12, 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 10316 CASCADE FALLS COURT OWINGS MILLS 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year 3/15/1937 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Min 280-30-7502 Hours OHIO Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits item 271s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10316 CASCADE FALLS COURT 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Acmed Forces: 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married FORCE BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TEXAS DEPARTMENT al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OF CORRECTIONS CORRECTIONAL OFFICER 4 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Is marked ELLERT SCOTT GRACE JOHNSON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, VERLENE SCOTT / WIFE 10316 CASCADE FALLS CT., OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once, 1 ☐ Burial 2 Ki Cremation 3 ☐Removal from State METRO CREMATORY 4/15/08 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 23a. Pa Ther the disease, or complications that caused the deatl or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between ause (Final 4eM **Physician** condition in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown Yes . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 2 🗸 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl Hospital: Other: P 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 \sum Nursing Home After this 5 Residence 6 □Other (Specify) 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 one) License number 0 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

YOUSEF GIFFAL MD 31. Date filed (Month, Day, Year) APR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23 CLDSRUADS DV. Ste 3HO
32 negistrar's Signature

Ste 3HO Owings Milb, MD 2111

# ■ Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Please	Type or Print in E			•		
	For State Registrar	State of Marylan	d / Department of F Certificate of		ntal Hygien Reg. No	0000	12557
Physician	1. Decedent's Name (First, Middle, L.	2 01	urdivant		Date of Death Month Da	400 400 400	3. Time of Death
/Medical Examiner Funeral Director	4a. Facility Name (If not institution gives the second of		Cehab 4b. City, Town, o	If Under 24 Hrs. 8. Hours Min.	19	9. Birthpl	ace (State or Foreign try)
Maryland a-f show	Usual Residence of Decedent  10a. State  10b. County	et more 10c. City	y, Town or Location	lle		10	0d. Inside City Limits 1 □ Yes 2 □ No
rs after death with the Maryla structure of the maryla structure of the maryla of the		idom Rd	10f. Zip Code	1228	10g. Ci	itizen of What Count	ry?
	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hif Yes, specify Cub. 1 □ Yes 2 ☑ No	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - America Black, White, e Specify:	
	15. Decedent's E (Specify only highest gi	ducation rade completed)  College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. F	Rind of Business/Ind BON Se	e taus
ges 1 and 2 should be filed within to of Health and Mental Hygiene. If I flem 27 is marked other than 'or other traumatic event, If a National To Re Compile	17. Father's Name (First, Middle, Las	binson		18. Mother's Name (F	First, Middle, Maider	- 10011	
1 and 2 sho Health and em 27 is m ther trauma	19a. Informant's Name/Relationship	liver-sister	19b. Mailing Address (Street  441 Roan  Research Disposition (Name of	and Number or Rural F	1. Caro	rsville.	MD 21228
it. Partimer	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation /5 ☐ Other (Spec  21. Signature of Funeral Septice/Lice	Removal from State	Place of Disposition (Name of emetery, crematory or other plan of the plan of	4-22	-08 Ba	etimore	e mdi
permi Depa Impo any ii	23a. Par 1. Enter he disease, or cor	nplications that caused the death	Gary P.	varch F.	espiratory arrest,	eto, md.	2/229 Approximate Interval Between
Physician /Medical	shock, or beart failure. List only Immediate Couse (Final disease or condition resulting in death)	a Due to (or as a co.s., l	uence of):	memon	re-		Onset and Death
ate be executed by the second of the second		b. Due to (or as a consequence of the consequence o	·	, drien	м		542
Attending Physician: The law requires that the death certificate b r death.  ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the biffication: To Be Completed by Physician/Medica	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 P No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic pregnand	у		23d. Date of delive Month	ery Day Year
e law requires that the do has been signed by the ge 2 should be detached mpleted by Physic	Fait II. Other significant conditions	contributing to death but not resu	ulting in the underlying cause giv	ren in Part I.		use contribute to th	
ificate has been sor, page 2 should				26. Place of Death (	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N	prior to con death?	osy findings available inpletion of cause of 2 No
ng Physiciar ter this certif neral director	examiner?	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 DOA Oth	er: 4 Nursing Home		6 ☐Other (Specify occurred	·)
r = E E	Natural 5 Pending investigation  2 Accident Suicide 6 Could not 1  4 Homicide determined	on 280 Place of Injury - At ho	M 1 □	Yes 2□No	. Location (Street a City or Town, Stat	nd Number or Rural te)	Route Number,
To the Hospital within 24 hours are to the Funeral I completely filled Medical Ce	29a. Certifier Certifying P (Check only one) Cmedical Example (Check only one)	hysician: To the best of my knominer: On the basis of examina and manner stated.	wledge, death occurred at the ti tion and/or investigation, in my o	me, date and place, and ppinion, death occurred	d due to the cause( at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
To t		La p	hsi ain	2976	9 29d. Da	ate signed (Month, L 4 /17 (	) 8
State	30. Name and address of person who	completed cause of death (Item  1. Completed cause	n 23å) (Type, Print)	, as koll	i'my by	Prof	v hay
Registrar	APR 1 7 200	Sien &	Species				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 8:30 PM Snow 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 62 Days Months 218-42-3031 1 ☐ M 2 🗡 F BNALKAM Director Nevember 18 1945 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1. Yes 2 No GOOMIT/AFI Director 10e. Street and Number 10g. Citizen of What Country? Sout Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: ð BIAL 3₹Widowed 4☐Divorced Completed er than "natur the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mocker to state 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked ot any linjuy or other traumatic even once. VERONILA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shelli Snow Ajibade 4307 LASAILE AVE BaltINOGE MARY AND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State LANSDOWNE MARYLAND April 16 2008 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion CEMETERY 21. Signature of Funeral Service Licensee 3636 W. TOREST PANK AVR. 22. Name and Andress of Facility A. P. surver Brown 7.78, that a sport 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Necrotizino acute /Medical Due to (or as a consequence of): **Examiner** Renel Ferlin Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Feilun Kespiratory and Due to (of as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after com.

To the Funeral Director. Af

Medical State

nier 31. Date filed (Month, Day, Year) 2008 APR Registrar

29b. Signature and title of certifier

29a. Certifier

Greene

30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

🔍 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

18230

Baltimore

Street

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2008

USA

N/A

9:10A

9. Birthplace (State or Foreign Country) ΜΓ

WHITE

MD

10d. Inside City Limits

1 TXYes 2 □ No

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL STANLEY STEIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2903 FALLSTAFF ROAD, #205 BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/28/1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 2 🗆 F Months Hours Min 83 215-14-6824 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f shov dical Examiner must be notified at Director BALTIMORE N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2903 FALLSTAFF ROAD, #205 21209 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by 3 Nidowed 4 Divorced is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURER'S REP **FURNITURE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be f h and Mental I STEIN HELEN HIGHSTEIN IRVIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a tant: If item 27 is 11 MERINO COURT, OWINGS MILLS, MD BRIAN STEIN / SON : If item 27 20b. Place of Disposition (Name of ANSAIE EMONAH or other place) AITZ CHAIM CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 04/16/2008 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Due to (or as a consequence of) P.O. Box 68760,

Examiner

ng physician and as the burial-transit Physician/Medical use õ detached þ Completed page 2 Be Certification: To

the þ has certificate Hospital or Attending Physician: neral Director: After this of filled in by the funeral dir 24 hours after death. Funeral Director: A completely

within 2. To the I

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

APR 1

7 2008

Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗆 Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

pleted dause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13,2008 **Physician** Arlene Μ. Stylc April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F Months Days Hours Min. Oct19,1948 Director 215-52-1508 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dkat Examiner must be notifled at Md. Baltimore City 1 X Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3809 Hudson Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner and. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 🎾 No Specify White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Office Manager <u>Spec Print</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Schultz Cora Libeig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry K. Stylc (husband) 3809 Hudson Street Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1x Burial 2 □ Cremation 3 ☐ Removal from State St.Stanislaus Cem 4-16-2008Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaciliKaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 es 2 🗌 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**V** No Be 26. Place of Death (Check only one)

sician and & The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral directions.

the

death with

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Simon V. Scalia, M.D. 2801 Hudson St. Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year) 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Marylan				lealth and Death	Mer	-	•	2000	3	1256
R.		Registrar  1. Decedent's Name (First, Middle, Las	t)		Tince	ite or i	Dealit	2.	Date of De	Reg. No	o.C U U (	J	3. Time of Death
Physician		Viola Estelle Th	nompson						Month	Da	2008 Year	.	4:22 P
/Medica		4a. Facility Name (If not institution, give			4b. Cit	y, Town, o	r Location of Dea	_	PLIL		c. County of De		
		2919 Clayton Roa	ad		Jo	ppa					Harford	Ē	
Funeral		Social Security Number     6. Se	7. Age (In yrs.	**	if Und Month	ler 1 Year s Days	If Under 24 Hr Hours Mir		Date of Bir (Month, Da	th ay, Year	9. B	irthplac	ce (State or Fore
Director		220-03-4399	86	Yrs.					ct. 1				ryland
and w	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation		-					100	I. Inside City Limi
Maryl f sho	<u></u>	Marrel and II	a	-									1 □ Yes 2√2 N
the I	Director	Maryland Harfo  10e. Street and Number	ora	<u>_</u>	oppa 10f. 2	Zip Code	-			10g. C	itizen of What C	Country	1?
with sa or		2919 Clayton Ro	had.		1.0		21085			3	USA		
d 21215-0036  dilled within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Dec		lispanic Origin? ( an, Mexican, Pue	Specify	Yes or No	)-	14. Race - Am		
S after 60	2	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes ②【 No					erto Ric	an, etc.)		Black, Wh	nite, et	C.
Exal.;	2	3 ☐∰Vidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 LJ Yes	2 <b>3</b> No	Specify:				Specify:	√hi	te
21215-0036 d within 72 hours after or giene. The Medical Examiner.	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Us	sual Occup	ation during most of we	orkina		16b. l	Kind of Busines	s/Indu	stry
Mithin Aithin Pan (1) 19 19 19 19 19 19 19 19 19 19 19 19 19	E E	Elementary/Secondary (0-12)	College (1-4or 5+)				1)						
L21	3	17. Father's Name (First, Middle, Last)		HO	mema	ker	18. Mother's Na	(F	inat Adielella	Adminis	Own Hon	ne	
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	Re	Leroy (unk) Richa	rdcon								n Surname)		
Taryla 2 should and Men is marke aumatic	0	19a. Informant's Name/Relationship (T		10h Mailie		(Ctt	Eva (1				T	7. 0	- 4-1
Mal d 2 st th an 7 is r					-		and Number or F						oae)
		Kristine Miller / 20a. Method of Disposition	20b. F	Place of Dispo	sition (N	lame of	Rd., P	y <u>tes</u>			D 21132 ocation - City o		n. State
nor		1 ☐ Burial 2 🖫 Cremation 3 ☐	Removal from State	cemetery, crei	matory o	r other plac	· .	1			,		
Baltimore, semit. Pages 1 at Department of Hee mportant: If item not injury or other more.	1	4 □ Donation 5 □ Other (Specify	1111	lltop :	Serv	ice C	orp 4	17-(	)8	To	wson, M	lar	land
Ba Ba	Į			Me	cCom	as Fu	ss of Facility neral Ho	ome,	P.A	•			
	_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused he deat	th. Do not ent	SL/ ter the m	COKES ode of dvir	bury Rd	ac or re	Abingo espiratory a	don ,	MD 210	A	pproximate
Physician		shock, or heart failure. List only of immediate Cause (Final	one cause on each line.							,			nterval Between Inset and Death
Physician /Medical		disease or condition resulting in death)	a. metasta  Due to (or as a consequence)		ma	CLL	uez					+	
Examiner				1401100 01).									
	<u>je</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):									
executed in and ial-transit	E	that initiated events	C.									į.	
8760, Kerrented into burial-transit	Ĭ	resulting in death) Last	Due to (or as a conseq	uence of):									
8760, cate be exphysician at the burial	dica		d									-	
	9	IF FEMALE:											· <u></u>
Box 6 leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta	al death 3[		pregnancy	/				23d. Date of d Month	-	ay Year
D. In the a hed for hed for hed for hed for hed for hed for he a hed for he a hed for he a hed for he a he a he a for he a he a he a for he	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of c 9⊡Unknown	death 5	Other (	(specify)				-	Wont		ay (car
P.O. that the ded by the detached	£	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlyina	ı cause niv	en in Part I		23e Did t	obacco	use contribute	to the	cause of death?
dS, F	2		, in the second part not not	anning in the d		, oddoo gir	on mer are i.				2		1
w requir	Completed												
Rec ne law has l	Ě							-	24a. Was	DSV	24b. Were prior to	autops comp	y findings <i>a</i> vailat lietion of cause o
al F	3								perfo	2 N	lo 1 🗆 Ye	s 2	□ No
Vital Residents The certificate herector, page	å å	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of De						
Phys ral diis	0	1 Yes 2 No.	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o		DOA	4 L. Nursing				6 □Other (Sp	ecify)	
on or ding Physis of After this of funeral directions.	0	1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	Injury	М	28c. Injur Wor	yat k? Yes 2∏No	200	. Describe	now inju	ary occurred		
Division or Vital Records, P.O. Box or or Attending Physician: The law requires that the death cer after death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At he	l ome. farm. str			105 2 1110	28f.	Location (	Street a	and Number or I	Rural F	Route Number
Div after In by		4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	fy)		.,,		20	City or To	wn, Stai	te)	runut i	rodic ridinber,
		29a. Certifier  (Check only  2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina	owledge, deat	h occurre	ed at the tir	me, date and place	ce, and	due to the	cause(	s) and manner:	as stat	ed.
the H iin 24 the F iplete	Medical	one)	and manner stated.					Juliou	acuse unie,				
To To Com	2	29b. Signature and title of certifier			2	9c. Licens				29d. Da	ate signed (Mo	nth, Da	y, Year)
		1 Down				D35	5275			Apr	1.1151	200	8
h		30. Name and address of person who c				. 1							
<i>y</i>		31. Date filed (Month, Day, Year)	32 Annietrario Siano	w. MA	e Ph	A. /							
State	e r	1. Date filed (Month, Day, rear)	32 Registrar's Signa	H. A	Bell	1							

08-02902 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Karen Ramond Tuite 1- For State Certificate of Death Reg. No Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 13, 2008 Year 1201 hrs **Medical Examiner** Ramond Karen Tuite 4b. City, Town, or Location of Death 4c Arme Arundel 4a. Facility Name (if not institution, give street and number) rince George's Pasadena 916 Longview Avenue g. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Director 212-76-3121 Nov24,1959 48 2X F Maryland 1 M Usual Residence of Deceden 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County 1 Yes 2 No altimore, MD 21215-0036
mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Mental Hygiene.
pportant: If tiens 71 is marked other than "natural", or items 23a or 28a-f show irry or other tranmafit event, the Medical Examiner must be notified at ones. Md. Anne Arundel Pasadena Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 916 Longview Avenue U.S Funeral 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12th Self-Employed Auto Sales 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John P. Bielski, Madeline Bayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 916 Longview Avenue Pasadena, Md. 21122 William E. Tuite (husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Crest Lawn Mem Gar 4-19-2008 Marriottsville, Md Donation 5 Other Specify 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 BHL 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Methadone Intoxication and Cocaine Use Complicating Chronic Approximate Interval Physician Mudica Death Obstructive Pulmonary Disease Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of) Segreptially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED per me g878 4-17-08 vt<sup>23a</sup>,27,28a-f per ME g878 4/29/08 Physician/Medical X UNPENDED been signed by the attending physician a rould be detached for use as the burial -Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes 2 No Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medical of Vital Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 this ဥ 1 V Yes No 2 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: o 24 hours after death.

e Funeral Director: A letely filled in by the fu 1 Natural Division 1 Yes 2 X No Pending Fnd 4/13/08 Fnd 12:03p 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide or Town, State)
916 Longview Ave., Pasadena, MD determined (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 14, 2008 O.C.M.E. (sup) 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD

ORIGINAL

State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14. 2008 Michelle Taylor April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 41 1 □ M 2√2 F 1966 Maryland 11. Director 214-80-2246 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hvoiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "Modical Examinar must be notified at 1 ☐ Yes 2 No Md. Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 8012 Eastdale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Superior Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geraldine Cirri Joseph Augustyniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Samantha M. Olsen(cousin) 7800 Wynbrook Road Baltimore, Md. 21224 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1:
Department of He
Important: If iten
any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4-18-2008Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniorlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran 68760, Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 2 □ No 1 ☐Yes 2 No Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this ð 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64395 APRIL 14, 2008 18 30. Name and address who completed cause of death (Item 23a) (Type, Print) 6565 N CHAMES ST, SUITE 209 BALTIMORE, MO 21204 DANKLIE OBERMAN, MO 31. Date filed (Month, Day, Year) State APR 1 7 2008 Registrar

Certificate of Death

4b. City. Town, or Location of Death

HARBOR VIEW

2. Date of Death

APRIL 11,

. 2<u>008</u>

4c. County of Death

BALTIMORE

Race - American Indian Black, White, etc.

Specify: WHITE

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

12564

3. Time of Death

Birthplace (State or Foreign Country)

MD.

10d. Inside City Limits

Approximate Interval Between Onset and Death

peux.

1 ☐ Yes 2 No

1:23A M

For State Registrar

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

535 45TH STREET

VIRGINIA

5. Social Security Number

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
APRIL 12, 1 □ M 2 🕁 F 218-03-3973 86 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location HARBOR VIEW MD. BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 535 45TH STREET 21224 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specity: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 6TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NORA SUMMERS JOHN DAWKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GORDON TOLSON/HUSBAND 535 45TH STREET, BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 4/14/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Enter the dishas List only shock, or heart failur Adult Failne to Mrine Symbonie. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No Completed 24a. Was an autopsy performed 2 200 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

funeral director

32. Registrar's Signature

3108 Bank ST

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DZIY6Y

DHMH 17 Rev 1/2001

within 24 hours of To the Funeral D completely filled in To the Hospital

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

eluto, ms. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart  State of Maryland / Depart  Certification	ment of Health and M	lental Hygien	2000 1200
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Emples on Thiel		Month Da	13, 2008 1:20 P M
	/Medic	-	4a. Facility Name (If not institution, give street and number)  4	b. City, Town, or Location of Death		c. County of Death
	Examin	er	Crenesis Cromwell	Pa- 2-11e		Baltimore.
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director	İ	214-12-4804 1 M 2 F 93 Yrs. N	fonths Days Hours Min.	(Month, Day, Year 9/12/1914	Country) MD
-		}	Usual Residence of Decedent		31 1 1	
	yland yland		10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits
	Mar F-f st	ţ	MD BALTIMORE MONKTON			1 ☐ Yes 2X No
	r 28g	Director		10f. Zip Code	10g. C	itizen of What Country?
	3a o		3300 JARRETTSVILLE PIKE	21111		USA
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
ဖွ	within 72 hours after death with the Maryland ene. than "ratural", or Items 23a or 28a-f show he Madical Exam increment the notified at	正	1 □ Never Married 2 □ Married 1 □ Yes 2 TXNo	Yes 2 X No Specify:	, , ,	Specify: WHITE
ဋ္ဌ	ral',	d by	3 XWidowed 4 □ Divorced Year or Dates:			
ည	72 h	Completed	(Specify only highest grade completed) (Give kin	it's Usual Occupation of of work done during most of work		Kind of Business/Industry
2	ithin Ban Man	npl	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		OLDY WOLKE
7	filed wi Hygien other th	Ö		MEMAKER	e (First, Middle, Maide	OWN HOME
	tal H	Be	17. Father's Name (First, Middle, Last)		KALAS	iii Sumame)
Maryland 21215-0036	2 should be and Mental is marked or aumatic ever	၉	STEVE KALINOSKI			car Tourn State Zin Code)
Ja	2 sh i and is m raum	1		Address (Street and Number or Run JARRETTSVILLE PI		TON, MD 21111
	s 1 and 2 should be filed within 72 hours after death with the Manylan I Health and Mental Hyglene 1 Health and Mental Hyglene 1 Health and Mental Hyglene 1 Health at I is marked other than "ratural", or items 23a or 28a-1 show item 7 is marked other than "ratural Exchit Let notified at other traumatic event. The Medical Exchit Let notified at					Location - City or Town, State
timore,	Pages 1 nent of H int: If ite iry or ot		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	tory or other place)		
<u>=</u>	men tant: jury		'4 □Donation 5 □Other (Specify) ST.STANI			BALTIMORE, MD
Bail	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ODCE.			Address of Facility MILL  415 BELAIR RD	BALTIMORE,	FUNERAL HOME, INC.
_	707 e o		( ma)			Approximate
			23a. Part1. Enter the disease, o complications that caused the death. Do not enter shock, or heart failure state only one cause on each line.	the mode or dying, such as cardiac	or respiratory arrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Deling droft in			weakes
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	Examine		Sequentially list conditions, b. Ans roll is			weeks
	₽ (; #;	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury			
	tran	cam	that initiated events resulting in death) Last  C. Due to (or as a consequence of):			Year)
8760,	cate be executed ohysician and the burial-transit	Ê	Due to (or as a consequence or).			V 79
876	hysic the b	dical	d			
9	as as	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	ath c	jan	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ed	ctopic pregnancy Other (specify)		Month Day Year
o o	0 0	ysic	1 Yes 2 Ao 9 Unknown	mer (specify)		
P.O.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ŝ	ires tha signed I d be det	by	la il	,g	1 ☐ Yes	2 ☐NO 3 ☐ Probably 4 ☐Unknown
0	w requir been si should	etec			24a. Was an	24b. Were autopsy findings available
Sec.	e law has t	npl	dysphyin		autopsy performed?	prior to completion of cause of
Division of Vital Record		S			1 Yes 2 →	
Viti:	Physician: this certificant all director,	Be	25. Was case referred to medical examiner?	Other	th (Check only one)	
of	shysi this al dir	2	1 Yes 2 No 1 Inpatient 2 EH/Outpatient	3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify)
n C	After uner	ono	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	250. 2500125 1150 11.	,aly coolings
S	death death tor: the	icat	2 Accident investigation 3 Suicide 6 Could niced 28e. Place of Injury - At home, farm, stree		28f. Location (Street	and Number or Rural Route Number,
$\leq$	after after Direc	Certification;	4 ☐ Homicide determined building, etc. (Specify)	i, ractory, ombe	City or Town, Sta	ate)
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o	occurred at the time, date and place	and due to the cause	(s) and manner as stated.
	24 hc 24 hc Fun stely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investore) and manner stated.	stigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	ithin o the omple	Mec	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
1	⊬ 3 F 8		1. 1 1/10	P31295		4/14/08
7	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)		
	Q		West Klosz 6701 N Charles St	- Suite 4202	70 wson	Ind 21204
	Sta	ate	31. Date filed (Wonth, Day, Year) 32. Registrar's Signature			
	Regist		30. Name and addless of person who completed cause of death (Item 23a) (Type, Proceedings of the Complete State of the Complete Stat			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Torree-Kristen Wimbish 2008 April 10:00am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Prince Georges PG Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (Stete or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 280 F Months Hours 04/08/2008 Maryland 1 Day N/A Yrs. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Marylend Hygiene. 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes A No Oxon Hill MD Prince Georges Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20745 USA 2105 Alice Ave #104 Funeral 14. Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐xNo If Yes, Give Year or Dates: Never Married 2☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N / A College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Krishanna J. Johnson Torrence L. Wimbish 19a. Informant's Name/Relationship (Type, Print)
Krishanna J. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Alice Ave #104 Oxon Hill, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 25 ☐ Cremation 3 ☐ Removal from State 4/15/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee W. Wesley Chavis III Funeral Service P.A. 10684 Southern MD BLVD Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examine attanding physician end for usa as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown á 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? cartificete has been si irector, paga 2 should I Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA Certification: To 2 ER/Outpatient 28c. Injury at Work? 27. Manner of beath 28d. Describe how injury occurred 28b. Time of Neturel 2 Accident 5 Pending 2 🗆 No investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours of To the Funeral I 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier 623 who completed cause of death (Item, 23a) (Type, Print) . Fomufod, MID toine

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

More .

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death WEATHERMAN **Physician** ATRICIA 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Medical Center Anne Arunde Annapoli el If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 225-62-8740 Director November 5, 1944 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Moral Hygene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evant in traust by natified at 1 Yes 2 No Director Mary land Annapolis Anne Arunde 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Glenwood 21401 USA 701 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Health Mental Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Ann Weatherman Wessell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. A Phy Ilis 7016lenwood Annagalis MD 21401 Gibbs 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 15,2008 Anatomy Gifts Regista Hanover MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 2. Name and Addr of Faulity Anatomy Gifts Drive Suite Hanover MD 210 Connelley 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ·WC /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Il-transit requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 ☐ Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the dead of the de 29a. Certifier and manner stated. 29b. Signature and title of cortifier FENSE HIGHWAN ANNAPOLIS MOZIKU) eted cause of death (Item 23a) (Type, Print) Name and address of person who c

Registrar

State

31. Date filed (Month, Day,

Year)

m

Registrar's Signature

441

		Please Type or Pri							•
	•	State of M  State of M  Registrar	laryland /		artment of H <i>rtificate of I</i>	lealth and Me Death		jiene eg. No. 200	3 12568
خر (9	ų.	Decedent's Name (First, Middle, Last)				2	Date of Deal	-	3. Time of Death
Physicia /Medic		DOROTHY EVERITT WARD					Ц	13 200	8 5:45 рм
Examin		4a. Facility Name (If not institution, give street and number	)		4b. City, Town, or	Location of Death		4c. County of Di	FORD
Funeral		5. Social Security Number 6. Sex 7. A 1	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.   8 Hours   Min.	B. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country) [arvland
Director		Usual Residence of Decedent				1	My 12/	1525 1.	
nyland		10a. State 10b. County	10c. City, To		cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f	cto	Maryland Howard	Elkri	age				10g. Citizen of What	
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural", or Items 23s or 28s-f ehow ent, irs Medical Examination notified.	Funeral Director	10e. Street and Number	01		10f. Zip Code 21 075			USA	Country :
eath	era	7074 Ducketts Lane Apt. 1  11. Marital Status 12. Was Deceden	t Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Spec	ify Yes or No-	14. Race - A	merican Indian,
or iter	Fun	1 Never Married 2 Married 1 Yes 2 €			If Yes, specify Cuba 1 □ Yes 2 No	an, Mexican, Puerto Ri  Specify:	ican, etc.)	Black, W	rnite, etc.
ours a	d by	Widowed 4 □ Divorced If Yes, Give Year or Dates							White
and 2 should be filed within 72 hours that had maked other than "natural", other traumatic event, the Modical Exited Exited Page 18 and	Completed	15. Decedent's Education (Specify only highest grade completed)	1	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	9	16b. Kind of Busine	ess/Industry
withir ene. then	dmo	Elementary/Secondary (0-12) College (1-4or		Teac		-7		Catholic	Education
Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (	First, Middle,		
Aenta Aenta rked ric ev	O B	Emmett Banks Everitt				Catherine			
42 should be filed within h and Mental Hygiene. 7 le marked other then "traumatic event, tra Me.		19a. Informant's Name/Relationship (Type, Print)	1			and Number or Rural			
permit. Pages 1 and 2 Department of Health a Important: If Item 27 ie any injury or other tra		Michael D. Ward / Son	70h Place	074	Duckett I	ane Apt.	101, El	kridge, M	D 21075
Pages 1 nent of He int: If ite		20a. Method of Disposition 1	9		osition (Name of matory or other pla	1			
it. Pa		4 Donation 5 Other (Specify)  21. Signature of Fundial Sparing to Licensee	Bel			Grdn 4-17-		Bel Air,	Maryland
permit. Departrimporta		RIVING POA	1	M	cComas Fu	ss of Facility ineral Home	e, P.A.	rdon Marr	1and 21009
		23a. Part1. Enter the disease, or complications that caus shock, or heardfailure. List only one cause on each	ed the death. [	Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory ar	rest,	Approximate Interval Between
Physician		1 0 (5'1				EN DS7			Onset and Death
/Medical		resulting in death)  a	is a consequen	ice of):	>13 C 7/3 E	1	<i>// \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </i>		
Examiner	L	Sequentially list conditions, b.	- Var at to 100 at 170 at 1						
/ Ped tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	is a consequen	ica oi).					
executed in and ial-transit	хап	that initiated events c.	is a consequen	nce of):					
e be ex	-	d							
tificate og phys as the	ledic			-				1	.nove
th cert rendin	an/N	IF FEMALE: 23b. Was decedent pregnant 1  Live birth	ne of pregnancy 2  Fetal de		□Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
The course, the death certificate be executed.  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medica	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of deat	h 5[	Other (specify)			William	24,
that the ed by detac		Part II. Other significant conditions contributing to death	but not resulting	ng in the u	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
w requires the second of the s	d by	DYSPHAGIA, ASPIRATION	UPNA	EUN	DONIA,		1 🗆 🗅	Yes 2 No 3	Probably 4 Unknown
w requir	Completed				,		24a. Was	an 24b. Wer	e autopsy findings available to completion of cause of
The la	omp			,			autop perfo	rmed?   deat	h? Yes 2 No
VICION: 'iclon: 'sertifica	BeC	25. Was case referred to medical examiner?				26. Place of Death			
OI VITA Physicien: r this certific	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa		VOutpatie	nt 3 DOA			dence 6 Other (	Specify)
the fire	ion:	Natural 5 Pending	jury 28 Da <i>y Ye</i> ar)	Bb. Time o	Wo	ryat 2 ork? ]Yes 2 □ No	8d. Describe i	how injury occurred	
or Attanding of Attanding after death. Director: After in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of	Injury - At home	e. farm. st	treet, factory, office				or Rural Route Number,
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the the	ertii		etc. (Specify)	-,,			City or To	wn, State)	
ospita hours ineral	alc	29a. Certifier Certifying Physician: To the be	st of my knowle	edge, dea	th occurred at the t	ime, date and place, a	nd due to the	cause(s) and manne	er as stated.
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medical Examiner: On the basis and manner	stated.	n and/or ii			od at the time,		
with To t	Σ	29b. Signature and title of pertifier	443			se number		29d. Date signed (A	1
A)		/ // Milligan	196	١		5344		804/14	12000
20		30. Name and address of person who completed cause of	death (Item 2	3a) (Type	in As Alar	LLANDE XE	CA Are	= MA 7/1	78
St	ate_	SURESH DHANJANI MD  31. Date filed (Month, Day, Year)  APR 1 7 2008	strar's Signatur	re A	TOTO TYVE	1773 8/02- 4/6	TRICE	-, 1100010	/ / ٧
Regist		APR 1 7 2008 See	a St	So	out.				
1000				*					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	-	partment of H		lental Hygie	4000	12569		
			Decedent's Name (First, Middle,	Last)	^			2. Date of Death		3. Time of Death		
н	Physici /Medio		MICH	ELLE	WIL:	SON-WH	ITAKER	AP21 L	Day Year 2 009	5:20 PM		
	as 1 and 2 should be filed within 72 hours after death with the Maryland  Health and Mendal Hygiene  Health and Health and Health Health and Heal		4a. Facility Nama (If not institution,	give street and number)	10	4b. City, Town, or	r Location of Death	*	4c. County of Death	1		
			50N.	SECOUR	S Host	Da	eltim	are	NIA	+		
		tor	5. Social Security Number  21971-9549  Usuel Residence of Decedent	3. Sex 7. Age 1	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign try)		
			10a. State 10b. County	1/A	10c. City, Town o	Location	010		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No		
		Funeral Director	10e. Street and Number	igusta /	he	10f. Zip Code	229	10g.	Citizen of What Coun	try?		
980		by	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? d 1 \( \text{Yes} \) 2 \( \text{VNo}\) If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:			
21215-0036		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(C	ecedent's Usual Occup live kind of work done of e. DO NOT use retired	du <i>ring m</i> ost of work		At B	dustry Lek		
Maryland 2		To Be Co	17. Father's Name (First, Middle, L	IN LO	n		18. Mother's Name	e (First, Middle, Mai	iden Sumame)	2		
ary			19a./Informant's Name/Relationshi	p (Type, Print)	1 1	ailing Address (Street	1 4	2	ity or Town, State, Zip	Code)		
			Patricia E.	Yarbor-au			usta Ar		to, md,			
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	B □Removal from State	20b. Place of D	sposition (Name of crematory or other place	(e)	0 /	Location - City or To	1		
Ë			`4 □ Donation 5 □ Other (Spe	ecity)	Kung	mem +			andalls	TOWN, MD.		
Baltimore	permit. Pag Department Importent: It any injury o	, ,	21. Signature of Funeral Service L	Culeace	0	Name and Address	wallar	eFS. P		1.21229		
E	Physician and /Medical Examiner penulal-transit	32 /	23a. Part1. Enter the disease, or c shock, or heart failure. List o	emplications that caused the analysis on each tine	he death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death		
			Immediate Cause (Final disease or condition a. ANOXIC ENCEPHA26PATH)									
			Due to (or as a consequence of):  Sequentially list conditions, and any, leading to immediate  Due to (or as a consequence of):  PNUE MONIA  Due to (or as a consequence of):									
7		ē	Sequentially list conditions, if any, leading to immediate	b. Due to for as a	ナ, 人り人 consequence of	G PNU	IEMONI,	4				
		를	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. METASTATIC 2NNG CANCER  Due to (or as a consequence of):									
XX.		Examin										
8760,		cal		d								
89		Medi	IF FEMALE.							-		
P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certifics within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as to	/ Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	☐ Fetel death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ery Day Year		
σ.			Part II. Other significant condition	s contributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?		
rds		d by	- DIABET	ES 17 E 2:	217213			1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Dunknown		
Ö		Completed	- BIPGL	AR DISC	RDE	?		24a. Was an		psy findings available		
æ		E O	- ANE	MIA				autopsy performed 1 ☐ Yes 2 €	d?   death?	inpletion of cause of		
ita		BeC	25. Was case referred to medical				26. Place of Deatl	h (Check only one)				
<b>}</b>		ToE	examiner? 1 ☐ Yes 2 No		t 2 ER/Outpa	tient 3 DOA Othe	er: 4 Nursing Ho	me 5 🗆 Residenc	e 6 □Other (Specif	1)		
Division of Vital Records,		edical Certification:								escribe how injury occurred		
			3 Suicide 6 Could no determin				et and Number or Rural Route Number, State)					
			29a. Certifier (Check only one)  1. **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within To the comp	Me	29b. Signature and title of certifier	ZAP NII	7	29c. Licens		l l	Date signed (Month,			
	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECONRS PROSPITAL									
	7		SUDKIR PATEL 2000W BALTO ST. BALTO MD: 21223									
	Sta		31. Date filed (Month, Day, Year)  32. Redistrar's Signature									
	Registr	ar	APR 17	2008	w D.	GOBAL)						

Please Type or Print in Black Indelible Inks Ensure All Copies Are Legible.
State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 6:00 AM Dorothy R. Yosuico April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard 10001 Windstream Drive Unit 806 Columbia If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 21, 19 Birthplace (State or Foreign Country) **Funeral** 215-12-8448 1 ☐ M 2 💢 F 86 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Directo Columbia Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10001 Windstream Drive 21044 USA Unit 806 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White \$ 3 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Rhodes Sallie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Yosuico, Husband 10001 Windstream Drive Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/18/08 4 Donation 5 Dother (Specify) Marriottsville, MD 21. Signature of Funeral Service Licensee
Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 42.1 /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immortate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director: /-fiter this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0-18151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chi-Shiang Chen, MD 301 St. Paul Place Suite 409 Baltimore, MD 21202 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Records, Division or Vital CAPORA,

:00

ပ္ 5

State

31. Date filed (Month, Day, Year) APR 1 7 2008 Registrar

29b. Signature and title of certifier

ERNESTINE WRIGHT, M.D. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM

21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 04

Registrar DHMH 17 Rev 1/2001

State

APR 0 1 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0645 Elaine Marie Beckman 03 31 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1528 Sunnyside Road 0akland Garrett Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F 62 218-48-7594 Director 03/28/1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 USA 1528 Sunnyside Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No altimore, Maryland 21215-0036 Specify Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Motels & Homes Housekeeper 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked oth Be Selders Geraldine Ludvig Vernard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 528 Sunnyside Rd. Oakland, Maryland 21550 Vicki L. Callis/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrett CO. Mem.Gard 4/2/08 Oakland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Lic 32 South Sceond Street, Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTEVIOSCIENOTI Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine o the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 No certificate 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 ☐ Pending investigation Injury 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No I Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in 🛮 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar 31. Date filed (Month, Day, 2008 APR

Division or Vital Records, P.O. Box 68760,

State Registrar

Myung Hee Nam M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



D003516

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West 7th Street, Frederick, Maryland

32. Registr's Signature 0 2000

Registrar

APR 0 1 2008

1	For State Registra
4	Do codont's

		1 = For State Registrar		C	ertificate d	of Death		Re	g. No.		
The state of the s		1. Decedent's Name (First, Middle, L	ast)				- 2	2. Date of Death	n	(00)	3. Time of Death
Physic /Med			Donald	Crowe				Mar	rch 28, 200	8	8:15 AM
Exam		4a. Facility Name (If not institution, gi	,		4b. City, Tow	n, or Location			4c. County of		
4	ği.		9813 O'Mara Ave		av) If Under 1 Ye	ear If Under	Midla				egany
Funera Directo		220-26-9971 Usual Residence of Decedent	Sex 7. Age (I	In yrs. last birthdo 77 Yrs	Months Da	ys Hours	Min.	3. Date of Birth (Month, Day, Decembe	Year) er 01, 1930	Countr	Maryland
land ow		10a. State 10b. County	10	0c. City, Town or	Location			÷		100	d. Inside City Limits
Man, a-f sh	iç	Maryland A	Allegany			Mic	lland				1 Yes 2 No
ith the or 28	Director	10e. Street and Number			10f. Zip Cod	ie		10	g. Citizen of Wh	at Countr	y?
s 23a			O'Mara Avenue			21:				U.S.	
ter de Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	er in U.S. 1	<ol> <li>Was Decedent If Yes, specify</li> </ol>		igin? (Spec n, Puerto R	ity Yes or No- ican, etc.)	14. Race - Black,	White, et	
036 urs af al"; or Exam	þ	3 X Widowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 □ Yes 2 🔀	No Specify:			Specify:		White
Ind 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's I (Specify only highest g	iducation rade completed)	i (G	cedent's Usual Od	one durina mos	st of working	7 1	6b. Kind of Busi	ness/Indu	ıstry
121 within sne. than '	Į d	Elementary/Secondary (0-12)	College (1-4or 5+)	`life	e. DO NOT use re	tired) Labor			1	ire Co	ompany
e filed vall Hygie	ပို	12 17. Father's Name ( <i>First, Middle, Las</i>	2 2					First, Middle, M	aiden Surname)		mpany
lan Jid be Mental rked o	To Be		Wilbur Crowe	÷				M	ary McVeig	gh	
Marylanc nd 2 should be fi lith and Mental H 27 Is marked ot r traumatic ever	-	19a. Informant's Name/Relationship		19b. Ma	ailing Address (Str					. ,	· ·
ire, M is 1 and 2 of Health Item 27 I	1	Patricia Fiorita  20a. Method of Disposition	- Step-Daughter	20h Place of Di	19 sposition (Name o		lative R		on, Marylan		
2 8 5 E L		1 ☐ Burial 2 💆 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con	Removal from State	cemetery, c	rematory or other nberland Cr	place)		April 02, 2008	oc. Location - Co. Cumb	•	, Maryland
Baltimc permit. Page Department Important: If any injury or		21. Signature of Funeral Service Lice	nsee LS		22. Name and Ad				eral Home		530
		23a. Part . Enter the disease, or cor shock, or heart failure. List on	nplications that caused the	e death. Do not							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		ras of la	ungs, s	milla	11 010	101-Sm	Il cell		Onset and Death
/Medical Examiner	•	resulting in death)	Due to (or as a co	onsequence of):							
		Sequentially list conditions,	b. Due to (or as a or	onsequence off:							
outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	·	. ,							
iO, e exec ian an inial-tr	Exa	resulting in death) Last	Due to (or as a co	onsequence of):			-	-			
68/60, ficate be executed physician and is the burial-transit	Medical		<b>d</b> .								
£ 5, 6		IF FEMALE:	23c. If yes, outcome pf p	pregnancy					22d Data	of dolinon	
death ce	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 □Ectopic pregna 5 □ Other (specif)				23d. Date Monti		y Day Year
at the up the stacher	hys	9 □ Unknown	9□Unknown								
COLdS, P.O. w requires that the deben signed by the should be detached	b	Part II. Other significant conditions				_					cause of death?
requi	eted	Atheosdoctu	acrice pain	nena y e	4136416					Proba	bly 4 Unknown
The lar	Completed		Colonaly	arky	diseas	0		24a. Was an autopsy perform	/ pri-	or to comp ath?	sy findings available pletion of cause of
VITA iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				of Death (	Check only one	)		
OF Phys	년 :	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpat	IEIR 3 DOA	Other: 4 Nu njury at Work?	ursing Home		nce 6 Other		
VISION Attending or death. rector: Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	<i>ear)</i> Injur		Worƙ? 1 ∐ Yes 2 ∐			,,		
DIVIS II or Atte after dez I Directo	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		- At home, farm, Specify)	street, factory, off	ice	28	f. Location (Str. City or Town,	eet and Number State)	or Rural I	Route Number,
LIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director;	ledical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of m miner: On the basis of ex and manner stated	camination and/or	eath occurred at the investigation, in r	e time, date ar ny opinion, dea	nd place, ar ath occurred	nd due to the ca d at the time, da	use(s) and manrate and place, an	ner as sta d due to t	ted. the cause(s)
To the To the To the Complex	Me	29b. Signature and title of certifier		2	I .	ense number		- 1	d. Date signed (		*
	VA	1/ Mm	Harl	in	D.	2148	8		Mach	28,	2008
	5	30. Name and address of person who	completed cause of death		e, Print)	/ -	1	/	Mach		4.65
Si	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	20 Vou	5145	HUC,	Long Co.	NHY, M	1	61139
Regis		APR - 1	2008	B	Sneath B						

DHMH 17 Rev 1/2001

3/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 5:10A M ,2008 Raymond Forinash April 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) De Grace Bar If Under 24 Hrs. Harford Havre I If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X**M 2□F 88 August2,1919WestVirginia Director 233-26-8149 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f aho the Medical Examiner must be notified at Maryland Cecil Conowingo 1X Yes 2 □ No **Funeral Director** 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 25 Grace Ann Drive 21918 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1X Yes 2 No 1943 - If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Specify:White þ 3 Widowed 4 □ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within 7 alth and Mental Hygiene. 27 is marked other than "r rraumatic avant, the Mud Baltimore Department Elementary/Secondary (0-12) College (1-4or 5+) Shop Steward of Education 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Earl Forinash Myrtie Ann Swecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24112 19a. Informant's Name/Relationship (Type, Print) of Health a 916ChalmersStreet, Apt. A, Martinsville, Virginia Ken Forinash /Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 4-10-08 Elkins, WEstVirginia Elkins Memorial 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muchael 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Cardionyo Priysician 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical orinash, Kayimon IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia - Altheimer's 1 Yes 2 No 3 Probably 4 Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 2**X** No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Impatient 1 ☐ Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Avatural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No investigation ractor; 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 35012 30. Name and address of person who condited cause of death (Item 23a) (Type, Print) Bel Air, Md. 21014 per Chesapenka CYWLH J. Kevin no 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Amore DHMH 17 Rev 1/2001

**ORIGINAL** 

			For 1 _ State	State of Maryla		•					
			Registrar  1. Decedent's Name (First, Middle, La	et)		Certificate of	Death 	2. Date of De	Reg. No.	2008	3. Time of Death
	Physicia /Medic		Mildred Har	,				Month	Day	Year O 208	1355 M
	Examin Funeral Director		4a. Facility Name (If not institution, given the facility Name (If not institution, given facility Number 13-26-5385	stal@ EAS		EASTO	or Location of Death  If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar. 10	th v. Year)	County of Death  TALSO  9. Birthpi Coun  28 Mary	/ lace (State or Foreign try) 1 a n d
P	>		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town	or Location			,		0d. Inside City Limits
те Маг	8a-f sl ptifled	Director	MD Carol	ine			eston				1 ☐ Yes 2€ No
Neo ith with t	23a or 2 ust be n	ral Dir	10e. Street and Number 20726 Tammuxz	ena Drive		10f. Zip Code	2165		Unit	ted Sta	tes
A 21215-0036 fled within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important; or items 23a or 23a-f show Important; If item 27 is marked other than "natural; or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※☑No If Yes, Give Year or Dates:	U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - America Black, White, of Specify: Wh	
21215-0036 within 72 hours aff	e. an "natu Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work d)	king		nd of Business/Inc	lustry
22 2	lygien her th nt, the	S	1 2 17. Father's Name (First, Middle, Lasi	-1	M e	edical Ass	istant 18. Mother's Nam	a (First Middle			
Maryland	hental Frked of tic ever	To Be	George Freder		•		Vida M			,	
Maryla 2 should	is ma		19a. Informant's Name/Relationship		- 1	Mailing Address (Street					
<b>e, l</b>	Health tem 27 other t		Sharon Powe11/ 20a. Method of Disposition		. Place of	Disposition (Name of	i	ad, De		r , DE 1	
Baltimore,	ment of ant: If it ury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State (fy)		y, crematory or other pla aven Cemet		02/08	G1er	n Burni	e, MD
Balt permit.	Departi Import any inj once.		21. Signature of Funeral Service Lice	nsee Galcew		22. Name and Address 216 N. Mai	ess of Facility Fra n St Fe	amptom'l	Funer urg.	al Home. MD 2163	P.A.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the de	eath. Do n	<u> </u>					Approximate Interval Between
11	ysician Medical caminer		Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVI Due to (or as a cons PULMONA	equence o	EMBOLI					Onset and Death
petr	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons		of): 、					
<b>68760,</b> ficate be executed	physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a cons	equence o	of):					
.O. Box 68	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ Fr 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		2	3d. Date of delive	ery Day Year
rds, P.	n signed b	d by Pr	Part II. Other significant conditions	contributing to death but not r	resulting in	the underlying cause giv	ven in Part I.	23e. Did 1		/	ne cause of death? ably 4 □Unknow
Division or Vital Records, P.O.	cate has bee page 2 shoi	Completed						24a. Was auto perfo 1∐ Yes	psy ormed?	prior to con death?	psy findings available mpletion of cause of 2 No
Vita sician	rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minpatient 2	□ ER/Ou	tpatient 3 DOA Oth	26. Place of Dea			TO:	
ion or	ith. r: After this e funeral d	tion: To	27. Manner of Death  1 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. T	ime of 28c. Inju		28d. Describe		3 □Other (Specify occurred	y)
Divis	s after dea Il Director Id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		t home, fai	rm, street, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or Rura )	d Route Number,
e Hospita	n 24 hour ne Funera sletely fille	Medical O		hysician: To the best of my k miner: On the basis of exam and manner stated.							
To the	withi. <b>To tf</b> comp	Me	29b. Signature and title of certifier	Botsu		29c. Licens	se number 0 5 9 4 8 "	1	29d. Date	e signed (Month,	Day, Year)
			30. Name and address of person who John Bot'sis, M	completed cause of death //	tem 23a) ( Nas h				216	01	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		Care a				<del></del>	
рнмн	17 Rev 1/20	001	2 200			- Court					

State of Maryland / Department of Health and Mental Hygiene

					,	Cer	tificat	e of	Death		Reg. N	0.		3 Unrose	001
	61		1. Decedent's Name (First, Middle, La	ist)						2. Date of D Month		ay	Year	3. Time	of Death
П	Physici /Medio		Willis Junior							03			800	1:00	) AM
	Examir	A 20 M	4a Facility Name (If not institution, gi	re street and number)					4b. City, Town, or		_	c. County			
		- 51	415 D. Street 5. Social Security Number 6.	Sex 7. Ag	je (In yrs. la	st hirthday)	If Under		Mt. Lake	9 Date of B	ieth	arre	9. Birtho	lace (State	or Foreign
	Funeral Director			1 M 2□ F	73	Yrs.	Months	Days	Hours Min.	06/17	7193	4	Cour	ntry)	11ey <b>,</b> P <i>A</i>
	pue *	' [	Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						1	0d. Inside	City Limits
	Manyle f eho	ō	MD Garrett	-		untain		. Pa	rk					1 □ Y€	s 2 No
	28	Director	10e. Street and Number	•	Hout	an carr	10f. Zip		LIC		10g. C	itizen of V	Vhat Cour		
	h with		415 D. Street				21	L <b>55</b> 0	)			U	.S.A.		
	deet	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Vas Deced	dent of I	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or N to Rican, etc.)	lo-		e - Americ	can Indian, etc.	
920	within 72 hours after deeth with the Marylend ene. than "naturel", or frems 23a or 28e-f ehow he Madical Examiner must be notified at	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:			I□ Yes :	X				Specify	Whit	:e	
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16e. Deced (Give	kind of wo	rk done	during most of wo	rking	16b.	Kind of Bu	usiness/In	dustry	
121	within than than	ם	Elementary/Secondary (0-12)	College (1-4or	5+)		Fan :		ent OPR		Co	al M	ininc	,	
2	Hygi The T	ပ္	17. Father's Name (First, Middle, Las	t)		neavy	nqu.	сршс	18. Mother's Na	me (First, Middl				,	
lan	id be entai ked o	To Be	Willis David G						Mary L	. Steye	r				
Baltimore, Maryland 21215-0036	d 2 should be thend Mental 7 is merked or traumatic eve		19a. Informant's Name/Relationship Mary J. Glotfelts						t and Number or R						
e,	Heeling The the		20a. Method of Disposition	, , , ,	20b. Pla	ace of Dispo	sition (Nar	ne of		Date	_			own, State	
nor	2 o 5		1 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special Control Co			metery, cier r Park	-			/2008	Dee	r Pa	rk, N	1d	
alti	permit. Peg Depertment important: if any injury o	- 1	21. Signature of Funeral Service Lice	-		22	. Name ar	nd Addr	ess of Facility S	tewart					
ä	Den imp	Ņ	1 Chm Axre	dock	0	3	2. S	outh	n Second	Street,	0ak	land	, MD	215	50
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	plications that cause one cause on each l	d the death. ine.	. Do not ent	er the mod	le of dy	ing, such as cardia	c or respiratory	arrest,		!	Approxim Interval B Onset an	Between
	Physician /Medical		Immediate Cause (Final					_					1		
	Examiner		disease or condition resulting in death)	a. ather		rotic as a consec			isease					years	
		je			Due to (or	as a consec	puerice oi).						1		
	the death certificate be executed by the ettending physicien end sched for use es the buriel-trensit	Examiner	Sequentially list conditions,	b	Due to (or	as a consec	uence of):						-		
90,	oe exe	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that injury control county)	C											
68760,	physics the b	edical	that initiated events resulting in death) Last		Due to (or	as a conseq	uence of):						I		
Box (	certifi ding use esu	2		d											
	d for u		Part II. Other significant conditions	contributing to death t	out not resu	lting in the u	nderlving o	ause o	iven in Part I.	23b. Di	d tobac	co use co	ntributa 1	o tha caus	se of death?
P.O.	that the de ed by the e detached i	Physician/	diabetes mell				, ,			1,2	Yes	2□ No	3 ☐ Pro	bably 4	Unknown
S, T	S D S	þ	diabetes meri										T		
ord	v requires that been signed b should be deta	E E								24a. Wa	as an au rformed		av	ere autops vailable pricompletion o	or to
of Vital Records,	28 8	Completed										1	of	déath?	
alF	E # 9										Yes	2,21No	1	☐ Yes 2	.□ No
<u> </u>	Physician: The this certificate tal director, peg	o Be	25. Was case referred to medical examiner?	Hospitel:				0 0	thor:	Home 5 Re		c 🗆 🗀	/C-00	(6.1)	
o	Phys r this ral di	-	1 ☐ Yes 2 ☑ No 27. Manger of Deeth	1 ☐ Inpati 28a. Date of Inju (Month, Da		ER/Outpatie 28b. Time o		28c. Inji	4   Nursing	28d. Describ			- ' ' -	(y)	
lon	Attending Ir death. actor: After by the fune	ફ	1 Natural 5 Pending 2 Accident investigation		ay rear)	Injury	М		onk? ∐Yes 2∐No						
Division	or Attending I efter death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not determine	4 200. FIECE OF ITE	jury - At hor tc. (Specify	me, farm, st	eet, factor	y, office	•	28f. Location City or 7	(Street Town, St	and Numb ate)	ber or Rur	al Route N	umber,
_	Hospital	edicai C	(Check only 2 Medical Exu	hysician: To the best	of exeminati	vledge, deat ion and/or in	n occurred vestigation	at the t	time, date end plac opinion, death occ	e, and due to th urred at the time	ne cause e, date a	(s) and m and place,	anner es	stated. to the caus	ie(s)
	within 2 To the	Med	one) 29b. Signature and title of certifier	and manner st	iaiou.		29	c. Licer	nse number		29d. I	Date signe	ed (Month	, Day, Year	r)
ı	F 3 F 8		· -++	1.1				0	1533	3		3 13	110	8	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)								
		8	Thomas G. Johnso	on, M.D.	311 N	Fourt		reet	: Oaklan	d, MD	2155	0			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	rar's Signat	ture	1	100							

DHMH 16 Rev 6/95

ORIGINAL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 0 1 2008

Registrar's Signature

		1	State of Maryland / Depar		al Hygiene	
			Decedent's Name (First, Middle, Last)	2. Da	ite of Death	3. Time of Death
	Physicia		VI C.C.	Anr	i1 5, 2	008 Year 1:00 A M
	/Medic		LDLIICE COTTAINS	4b. City, Town, or Location of Death		:. County of Death
	Examin	er	Ta, t doing trains in that monday, give an extension,	Denton		Caroline
			Ruxton Health of Denton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8 Da	ite of Birth	9. Birthplace (State or Foreign
	Funeral		3. 30cial 36curity redirings	Months Days Hours Min. (M	lonth, Day, Year,	
	Director	-	216-18-8826	Ucto	ber 29, 19	22 Maryland
	pug *		10a, State 10b. County 10c. City, Town or Loca	ition		10d. Inside City Limits
	sho	č	P:1-1			1 ☐ Yes 2 ☐ No
	Ne N	ect	Maryland Caroline Ridgel  10e. Street and Number	. y 10f. Zip Code	10g. Ci	itizen of What Country?
	vith t	Director		21660		ed States of America
	ath v	rai	12231 River Road			14. Race - American Indian,
	er de Item	nue		as Decedent of Hispanic Origin? (Specify Y es, specify Cuban, Mexican, Puerto Rican,	, etc.)	Black, White, etc.
36	s aft	Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Year or Dates:	☐ Yes 2X No Specify:		Specify: Caucasian
8	hour	Completed by Funeral	A	nt's Usual Occupation	16b. 8	Caucastan  Kind of Business/Industry
7	"nat	lete	(Specify only highest grade completed) (Give ki	nd of work done during most of working O NOT use retired)		
2	within	m d	Elementary/Secondary (0-12) College (1-4or 5+)	Secretary		Education
77	be filed within 72 hours after death with the Maryland tal Hygiene d other then "natural", or Items 23a or 28e-f show event, i'a Medical Exactiner mout he notified at	ပိ	11 HS grad 2	18. Mother's Name (First	t, Middle, Maide	
Ĕ	d o d o	Be		Sr. EstherMar	win Cov	ington
Ž	2 should and Men Is marke sumatic	2	Daniel Donovan Hollingsworth, S  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Street and Number or Rural Rou		
a Z	12 st h and 7 Is r		- +s.totarara			
a)	is 1 and 2 of Health a item 27 is other trai		20b. Place of Disposition	l River Road, Ridgel	20c. l	_ocation - City or Town, State
0	ges toth Hite		cemetery, crema	atory or other place)		1 Manual and
<u>.</u>	men tent: jury			Cemetery 4/9/200	8 Gre	ensporo, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show amy injury or other traumatic event, the Medical Examinet must be notified at once.		Mc Machine Mc	Name and Address of Facility Dore Funeral Home, P	.A.	
_	20 = e a		1	2 South Second Street	t Dent	on, Maryland 21629 Approximate
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or resp	oratory arrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition ALZHEIMER)	S LEMENTIA		MONTHS
	/Medical		resulting in death)  Due to (or as a consequence of):			
L	Examiner		Sequentially list conditions b.			
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ocute nd trans	Examiner	that initiated events C.			
760,	be executed ician and burial-transit	ŭ	resulting in death) Last Due to (or as a consequence of):			
376	0 0	licai	d			
89	law requires that the death certifical as been signed by the attending phy? Should be detached for use as the	Physician/Med	IF FEMALE:			
Вох	th ce tend	an/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 E	Ectopic pregnancy		23d. Date of delivery  Month Day Year
	that the death ed by the atte detached for	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		
P 0	at the	Phy		desking source guest in Bort I	23a Did tohacco	use contribute to the cause of death?
ID.	es tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in the unc	senying cause given in Fart i.		2 No 3 Probably 4 Unknown
Ď	v requires been sign should be	ted				2400 001.10000, 100000
S	has be	pie			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records	0 L 0	Completed		1	performed? Yes 2	death? 1 ☐ Yes 2 X No
ita	sician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Cha	eck only one)	
>		S B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4 Nursing Home	5 🗌 Residence	6 ☐Other (Specify)
ı of	g Phys ter this neral di	T.	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 28d. I	Describe how in	jury occurred
<u>Ö</u>	ndin ath. r: Af	atic	2 Accident investigation	M 1 □ Yes 2 □ No		
Division	Afte ar de ecto by th	iffic	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)		ocation (Street a City or Town, Sta	and Number or Rural Route Number, hte)
	s after	Certification;		<u> </u>		
	hour hour ner		29a. Certifier (Check only (Ch	occurred at the time, date and place, and d	tue to the cause	(s) and manner as stated. Indiplace, and due to the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral di	edical	one) and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			Mayorkha ATTENDING 191	D0053094	4	-7-08
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)		
_				Avenue, Federalsbu	rg, Mar	yland 21632
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 8 2808	,		
	Regist	rar	MFN U COO			

**ORIGINAL** 

	1	For State Registrar		Maryland / Dep <i>Ce</i>	artmen <i>rtificat</i>					Reg. No.	008	125	84
Physician		<ol> <li>Decedent's Name (First, Middle, L</li> </ol>	ast)						2. Date of De Month	aath Day	Year		of Death
/Medical		Gavin Michael				-			3	27	2007		40 M
Examiner	r 4	a. Facility Name (If not institution, g		r)			Location of E	eath			County of Dea		
Funeral	5	428 Coolidge A		nge (In yrs. last birthday	If Under		If Under 24	Hrs.	8. Date of Bir	rth	Garrett 9. Bir	thplace (State	or Foreign
Funeral Director		218-79-4280	1 M 2□ F	Yrs.	Months 6	Days 1	Hours	Min.	(Month, Da	y, Year)	Cumi	ountry) perland	I, MD
Hygiane.  Wher than "netural; or Items 23a or 28a-f show ant, the Medical Examinar must be notified at a Completed by Funeral Director	-	Jsual Residence of Decedent											
d a	.	10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside	s 2 No
de dry vysere, de		MD Garre	tt	0ak1and	1 . 04 . 70		<u>.</u>			10- 00			
Dir.	בֿ   '	IOe, Street and Number			10f. Zip					Tog. Citi	zen of What Co	ountry ?	
ne 23	2 -	428 Coolidge Ave	12. Was Deceder	at Ever in II S 13		550	ispanie Origin	2 (Spec	rify Yes or No	n-	USA 14. Race - Amo	erican Indian.	
		1  Never Married 2  Married	Armed Forces	?? ] No			ispanic Origin In, Mexican, F	uerto F	Rican, etc.)		Black, Whi		
3	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:	1 🗆 Yes	2 🔀 No	Specify:				Specify: W	hite	
t, the Medical E	100	15. Decedent's l (Specify only highest g	Education		dent's Usua		ation during most of	workin	na	16b. Ki	nd of Business	/Industry	
matic event, it e Me. To Be Comple	<u>-</u>	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT u	se retired	1)		•				
		Control of Alexander Control of the	-41	1	nfant		40 14-15-1-	N	/Fire Mandal	14-/-	C		<del></del>
8	Ď	17. Father's Name (First, Middle, Las		T T					(First, Middle		Sumame)		
Tell C		Richard Michael  19a. Informant's Name/Relationship		II	ina Addross	(Stroot	-	-	n Maron		r Town, State,	Zin Codo)	
trau.		Richard M. Harv									1and 2		
any Injury or other traumatic ance.	- 2	20a. Method of Disposition	ey /rac	20b. Place of Disp	osition (Nai	ne of			ate		cation - City or		
y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Garrett	,	-	1	2/21	1 /00	0.01	and,M	arulan	a
	-	21. Signature of Funeral Service Lic									al Home	aryran	u.
ou o		I hom Hhas	elul &								1,MD 21	550	
ian lical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ed the ath. Do not en line.								Approxim Interval 8 Onset and	etween
iner		Sequentially list conditions,		respondence of):	brace	tin	fection					I wee	h-
dical Examiner	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Sm	A Type	. 1							4-5	mon H
Physician/Medical	ysiciallime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	⊒Ectopic pr □ Other (sp		,				23d. Date of de Month	livery Day	Year
۾	רבי	Part II. Other significant conditions	contributing to death	but not resulting in the	anderlying o	ause giv	en in Part I.				se contribute t	o the cause o	
snourd	- 10												
amo	-							_	24a. Whas auto perf	opsy ormed?	prior to death?	utopsy finding completion of s 2 <b>)</b> No	cause of
Be	2	25. Was case referred to medical examiner?				10.		Death	(Check only	one)			
		1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending 2 Accident investigati	Hospital: 1 Inpa  28a. Date of In (Month, L			28c. Injur	4 🗀 (40) 2)	2	ne 5 Res 8d. Describe		6 □Other (Spe y occurred	ecify)	
Certification:		3 Suicide 6 Could not determine	d 288. Place of I	njury - At home, farm, st etc. (Specify)	reet, factor	y, office		2	8f. Location ( City or To		d Number or R	ural Route Nu	umber,
Medical Ce		29a. Certifier To Certifying F (Check only one) 2 Medical Ex-	Physician: To the bes aminer: On the basis and manner	st of my knowledge, dea of examination and/or in stated.	th occurred rvestigation	at the tin	ne, date and p pinion, death	olace, a	nd due to the	cause(s) date and	and manner a I place, and du	s stated. e to the cause	9(s)
comp		29b. Signature and the of certifier					e number			29d. Dat	te signed (Mon	th, Day, Year,	)
		pulm	BA		H	00	6470	5		3	1271	2008	
	1 3	30. Name and address of person wh	o completed cause of	death (Item 23a) (Type	, Print)					-			
4	+	Richard A. Por			ourth	Str	eet, O	ak1a	and, M	D 21	1550		
State legistrar	•	31. Date filed (Month, Day, Year) $APR = 2$	32 <b>Aegis</b>	strar's Signature	nach	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Allison Holmes 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 29, 2008 0005 hrs **Medical Examiner** Allison Holmes 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Country) Months Days Hours Director 1958 577-88-6505 M 2X F Oct. 13. Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. County 1 X Yes 2 No Prince George's Suitland 28a-f show Maryland notified at once, with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2527 Ewing Avenue 20746 United States **23**n Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. death v Armed Forces? 1 X Never Married 2 Married Yes 5 Black Specify: Yes 2 X No specify: Divorced f Yes. Give Year à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "T or other traumatte event, the Medical E timore, MD 21215-0036 Self Employed 2 years Travel Agent 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Holmes Margaret Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 9202 Jena Rd. Spring Hill, FL 34608 Yvonne Johnson - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State tant: Lee's Crematory Apr 17, 2008 Clinton, MD Donation 5 Other Specify 22. Name and Address of Facility 1. Signature Funer Ser Stewart Funeral Home, Inc. icensee 4001 Benning Road, NE Washington, DC 20019 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and allure. List only one cause on each line. 'Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease *k*aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 23a, Pt.II, 27 per ME g878 4/28/08 amh X UNPENDED attending physician or use as the burial -O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Yes 2 ✓ No 3 Probably 4 Unknown Records, P. Diabetes Mellitus 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes

The law requires that the death certificate be executed icate has b page 2 sh this certificate h Hospital or Attending Physician: 24 hours after death. Division of Vital this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Completed Be Certification:

25. Was case referred to medical

1 V Yes

27. Manner of Death

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

31. Date filed (Month, Day,

1 X Natural

2

3

one)

Wedical

26.Place of Death (Check only one) Other<sub>4</sub> Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?

Yes 2 28e. Place of Injury - At home, farm, street, factory, office building, etc.

29c. License number

O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Residence 6

28f. Location (Street and Number or Rural Route Number, City

March 29, 2008

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Nursing Home 5

blelle

Pending

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner

and manner stated

State Registrar 32. Registar's Signature

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, Date of Death 3. Time of Death Month Year 0700 M **Physician** OR DAN 03 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Edgewater 3309 Old Point Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dav. Birthplace (State or Foreign Country)

Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🔀 F Yrs 06/23/1951 Director 56 160-44-9009 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21037 United States 3309 Old Point Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Occupational Therapist Medical 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be find and Mental H Elizabeth Bartley Charles Leman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any Injury or other trau 3309 Old Point Road, Edgewater, Maryland 21037 Marion H. Jordan/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Takemont Memorial Cardens 04/04/2008 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery signed by d

Be Completed by certificate has been si rector, page 2 should I Certification: To After this To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No No
25. Was case referred to medical	26. Place of Death (Check	conly one)
examiner? 1 Tyes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5	Residence 6 □Other (Specify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigat	(Month, Day Year) Injury Work?	scribe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad   286. Place of Injury - At nome, farm, street, factory, office   28f. Loc	ation (Street and Number or Rural Route Number, or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and prantier stated.	

29c. License number

E HO HWAY

30

Registrar

Medical

31. Date filed (Month, Day, Year) State APR 0 1 2008

29b<del>. Sig</del>nature and title of celtifier

Name and address of person who comp

neted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Physician Bertha Rebecca Kinder 2008 /Medical 4:10 PM March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis HealthCare The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🕅 F 97 212-12-0127 Director 10, 1911 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other than "the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Caroline Preston 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4362 Harmony Road 21655 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Sertha Kinder Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Examiner in Shipping Depart. Sportswear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Woods Jones Nora Sharp Jones ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Rebecca Hackett/Niece Baltimore, MD 21239 1621 Woodbourne Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State Coppins Cemetery 04/03/08 |Jonestown, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months disease or condition resulting in death) /Medical Due to (or es a consequence of): Examine Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b irector, page 2 s autopsy performed? Yes 2000 No 10 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4× Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 8♥ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 within 24 hours after To the Funeral Di completely filled in

> State Registrar

Medical

31. Date filed (Month, Day, Year)

MAR 3 1

29b. Signature and title of certifier

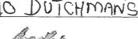
29a. Certifier

(ROWLEY 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2008<sup>ear</sup> Keeney Roland 10, 5:20pm <sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Northampton Manor Nursing Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 1 MM 2 □ F Months Days Hours Min. 7 2 217-32-5224 MD 12-23-1935 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County 1 ☐ Yes 2X No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Catoctin Hollow Road 13630 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐ Yes 21€ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sole Proprietor Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Keenev Belva Baugher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Keeney 13630 Catoctin Hollow Rd Thurmont MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □Removal from State 4/14/2008 Woodsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) Rocky Hill Cem. 22. Name and Address of Facility  $\,$  Keeney & Basford P.A. Signature of Funeral Service Lice M01176 106 East Church St. Frederick, MD 21701 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Chronic Obstructive Lung Disease resulting in death) Due to (or as a consequence of): Atrial Fibrilation Sequentially list conditions, Due to (or as a nonsequence of): than, loading to inmedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperhotestrolem 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shov dical Ex miner must be notifled at

other traumatic event, the Medical

Hygiene.

Pages 1 and 2 should be filed ment of Health and Mental Hyginnt: If item 27 Is marked other

permit. Pages 'Department of H Important: If ite any Injury or ot

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ပ

Examiner Physician/Medical ş Completed Be

မ

Certification:

cal

certificate be executed attending physician and for use as the burial-tran the signed by peen has page certificate this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral

Division or Vital Records, P.O. Box 68760.

Physician;

24a. Was an performe 2 Divin

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case referred to examiner?	medical		26. Place of Death (Check only one)						
1 Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3 🗆 D0	lome 5 ☐ Residence 6	Other (Specify)			
27. Manuel of Death 1 Natural 5 □ 2 □ Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1	28d. Describe how injury	occurred		
	Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, stree	t, factor	y, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,		
20a Cortifice 1 V C	Cartifying Ph	velaion: To the best of my kn	owlodge doath c	COLUEROS	at the time date and place	- and due to the source/s) a			

(Check only one

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

D0054636

29d. Date signed (Month, Day, Year)

4-11-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Haque M.D. 700 Montclaire Avenue Frederick, MD 21701 Syed W.

State Registrar 31. Date filed (Month, Day, Year) APR 17 2008



State of Maryland / Department of Health and Mental Hygiene 1- For state amend #8 Per INf G878 4/17/08 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year **Physician** 9, 2008 Larry Lee Lawson April 8:17 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1001 Rose Hill Ave. Washington Hagerstown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F 69 Director 219-34-5700 May  $\frac{25}{1938}$ Missouri Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland | Washington Hagerstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1001 Rose Hill Avenue 21740 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The marked other than "natural", or Items 23s mirt. If item 27 is marked other than "natural", or Items 23s ury or other traumatic event, the Medical Examiner must. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∰Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baker 12 Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick W. Lawson Fae E. Ham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene A. Lawson/Wife 1001 Rose Hill Avenue, Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/12/2008 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown Md. 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** YEARS /Medical Due to (or as a consequence of): **Examiner** YEARS ODDAGO ABUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autop performe 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie APRIL 10 D28810 2008 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of perso J. BLASH, MD 324 E. ALTRETAM ST SUITE 203 HAGERSTOWN MD 27740 STEVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 17

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:45 PM 2008 l, April DORIS **JEAN** MAIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Dec. 12, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 M 2 √2 F 70 218-34-3868 1937 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 717 Summit Avenue 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 Yes 2 XNo Specify: <u>Ş</u> 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Social Services permit. Pages 1 and 2 should be filed beartment of Health and Mental Hygit Important; If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles R. Crothers Evelyn Fraley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melanie J. Devin / Daughter 717 Summit Avenue, Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 4/5/08 Frederick, Maryland ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lux 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician men /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed/ res 2 No 1□ Yes the Hospital or Attending Physician: funeral director, 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. 27. Manger of Death 5 ☐ Pending investigation (Month, Day Year, Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be

Division or Vital Records, P.O. Box 68760,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Lycrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D65443

I WOVE MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elena Iarikova, MD 400 West 7th Street, Frederick, Maryland 21701

State Registrar

Medical

hin 24 hours a the Funeral I

within 24 hor To the Fune completely f

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

To the Funeral Director:

After

death.

within 24 hours after

To the Hospital or Attending

Be

2

Certification:

Medical

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

Year

himselt

25.	Was case referred examiner?  Yes 2□ No.		
27.	Manner of Death		
	1 Natural	5 Pending	
	2 Accident	investigation	١

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of (Month, Day 108

1 Tes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Shot est Sub

performed?

M KROWN 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Butler residence Frederick MD

26. Place of Death (Check only one)

200	(Check only	20
	one)	2

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) 2008

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South SAMIT

178071917

State Registrar

State of Maryland / Department of Health and Mental Hygiene? 12592

					Certificate of Death	Reg. No.	
	Physici /Medi		1. Decedent's Name (First, Middle, Last	MARINE		2. Dete of Deeth  Month  03 - 30 - 20	3. Time of Death
1	Examir		4e Fecility Neme (If not institution, give H05PICE H0US		ab, City, Town, o	T Location of Death 4c. County	RDUNE
	Funeral Director		5. Social Security Number 3.17-03-1541  Usuel Residence of Decedent	7. Age (In yrs. In	est birthday) Yrs.  If Under 1 Year  Months Deys Hours Mir		9. Birthplace (Stete or Foreign Country)
	Meryland Ff show	tor	10a. Stete 10b. County  AROL	INE FFD	, Town or Location PPALSBURG		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28a	Funeral Director	10e. Street end Number 313 RELIANCE	WEXUE	10f. Zip Code 21032	10g. Citizen of	Whet Country?
)20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. important: if flem 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,8 Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue)  1 Yes 2 No Specify:	erto Rican, etc.) Bla	ce - American Indian, ck, White, etc.
21215-0020	within 72 hou ane. then "neture to Medical E	Completed	15. Decedent's Edu (Specify only highest gred	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)  CLERICAL	orking	cusiness/Industry
Maryland 2	ould be filed within Mental Hygiene. arked other than ' atic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) RAY COLLING	5		ame (First, Middle, Maiden Surnar Y WARD	
	1 and 2 should Health end Men em 27 is marke other traumatic		19a. Informant's Name/Reletionship (7)  MARY LINDA THOM  20a. Method of Disposition	MASINEICE.	19b. Mailing Address (Street and Number or A 3728 HOUSTON BRAN ace of Disposition (Name of	UCH RD FEDERA	, State, Zip Code) 11052 PLSBURG MO - City or Town, Slate
altimore,	permit. Pages Department of I Important: If ite any injury or of page.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Removal from State	PITAL CRAMATORY	04/01/08 DOVEX	2, DE
Bal	permit. Departr Importu any init		21. Signature of Funeral Service Licens		22. Name and Address of Facility WILLIAMSON FU 311 S. MAIN ST. FE	DERALSBURG	i, m021632
- Salar	Physician		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death ne cause on each line.	. Do not enter the mode of dying, such es cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
* **	/Medical Examiner	er	Immediate Ceuse (Final diseese or condition resulting in death)		tic melanoma es a consequence of):		9months
o,	executed an and inal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):		
ox 68760,	certificete be executed ding physician and use as the burial-transi	≥	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of):		
, P.O. Bo	The law requires that the death certificate be executed ete has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	y Physician	Part II. Other significant conditions cor	ntributing to death but not resu	liting in the underlying cause given in Part I.	23b. Did tobecco use co	ontribute to the cause of death?
Division of Vital Records,	requir been s should	Completed by				24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
tal H	n: The ificete h or, pege	e Con	25. Was case referred to medical		26 Place of D	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No
of Vi	Physician: r this certific aral director,	: To Be	examiner?	28e. Date of Injury	ER/Outpatient 3 DOA Other: 4 Nursing 28b. Time of 28c. Injury et	Home 5 ☐ Residence 6 ☐ Ott	
ivislon	To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	1 Matural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At holbuilding, etc. (Specify	M 1 ☐ Yes 2 ☐ No me, farm, street, factory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
Ω	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical Ce	(Check only 2 Medical Exami	ner: On the basis of examinati	wledge, deeth occurred at the time, date and ple- tion and/or investigation, in my opinion, death oc		
	To the Within 2 To the comple	Med	29b. Signature end title of certifier	and manner stated.	29c. License number	29d. Date signe	ed (Month, Day, Year)
			30. Name end eddress of person who co	empleted cause of deeth (Item	23e) (Type, Print)	3/3/	108
			David Smith, 1	M.D. 8221 -	Teal Drive, Suite.	302 Easton	, MD 21601
	Sta Registr		31. Date filed (Month, Day, Yeer) APR 6-3 200	32 Pegistrer's Signat	ure de la		
011	MH 16 Rev 6/9	-					

Registrar DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Minnie Catherine Ours April 1:16 P 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** McHenry Garrett 78 Swamp Knox Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 👽 F Yrs. 220-34-1870 Director 85 Jan 28, 1923 West Virginia Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir than "naturet", or Items 23a or 28a-f show the Medical Examinational be multiped at 1 ☐ Yes 2 No McHenry Garrett Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21541 USA 78 Swamp Knox Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel", or Iter any injury or other freumatic event, the Medical Experiment ORE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Housekeeping Motel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cora Alt Walter Nelson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Swamp Knox Lane, McHenry, MD Doris Bittinger/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Blooming Rose Cem. Apr 4, 2008 Friendsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 Jane euradi 179 Miller St., Grantsville, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Dementia 455 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Dehydration Rhematoid Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has le 2 certificate 1 ☐ Yes 2 ☑ No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No ဥ 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a

To the Funeral 5
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 400 64705 08 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

Dr. Richard Porter 311 N Worth Forth St. Oakland, mD 21550 Dr. Richard 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29 Day 03<sup>Month</sup> Physician 2008 M 1855 SMITH PATRICIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Sex X 1 □ M 2 □ F **Funeral** Months 3/25/1951 Maryland Director 213-48-9314 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at State 1 ☑ Yes 2 ☐ No 0akland Garrett Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 107 S. Seventh St. 21550 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏋 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Catering Caterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked oth Terrence Carolan Mary E. Gravenstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 107 S. Seventh St. Oakland, MD 21550 19a Informant's Name/Belationship (Type. Print) Larry P. Smith Department of Health at Important: If item 27 is any Injury or other trau 20a. Method of Disposition
1☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 4/1/2008 Oakland Cemetery Oakland, Md 21. Signature of Funeral Service Research 22. Name and Address of Facility Stewart Funeral Home 32 S. Second Street, Oakland MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Be Certification: To

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 attending physician To the Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ending physician and use as the burial-transigned by the a within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Phys	9 ☐ Unknown	9_JUnknown								
þ		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobar  1 Yes								
Completed	Counadu	Congulopatty.		24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No						
<b>a</b>	25. Was case referred to medical		26. Place of Death	Check onl one						
Ö	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 Residence 6 Other (Specify)						
ation: 1	27. Mander of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred						
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical C	29a. Certifier 1 M Certifying Ph (Check only one) 2 Medical Exam	nysiclan: To the best of my knowledge, death oc miner: On the basis of examination and/or inves and manner stated.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)							
Me	29b. Signature and title of certifier	opula	29c. License number	29d. Date signed (Month, Day, Year)  3 3 6 0 8 10 PM						

Prive Cumberland, Mid

State Registrar 30. Name and address of person

TALIGO

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

900

M.D

2008

Registrar

DHMH 17 Rev 1/2001

State

Prashant

31. Date filed (Month, Day, Year)

Shutle

South Parke St

32 Registrar's Signature

+#400 Aberdeen mo 21001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15

			1- For State Registrar Ce	ertificate of			g. No. 2008	12597	
	Physici	an	Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)		2	. Date of Deat Month	Day Year	3. Time of Death	
100	/Medic	al -	W. LLIAM E: TRESSLER  4a. Facility Name (If not institution, give street and number)	4b. City. Town. c	r Location of Death	04	4c. County of Dea	21:40 M	
	Examin	ier	UNIVERSITY OF MARYLAND	BALTIMOR					
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday 14-46-5200 1 Age (In yrs. last birthday 59 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, ec. 21,	Year) Co	thplace (State or Foreign ountry) cyland	
faryland 21215-0036	/land low		10a. State 10b. County 10c. City, Town or L		1 - 1-			10d. Inside City Limits	
	e Mar 3a-f sh tiffied	To Be Completed by Funeral Director	MD Dorchester	H U	ırlock			1 ☐ Yes 2 🛣 No	
	23a or 24 ust be no		10e. Street and Number 4857 Skeet Club Road	10f. Zip Code	21643		Og. Citizen of What Co United S	tates	
	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Exminer must be notifiled at		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Pivorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ X ves 2 □ No If Yes, Give Year or Dates: 169-71	8. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:		ореспу.	e, etc. hite	
12	n 72 h "natu edical		(Specify only highest grade completed) (Giv	edent's Usual Occup le kind of work done . DO NOT use retire	oation during most of working d)	4	16b. Kind of Business	/Industry	
212	d withing giene.		Elementary/Secondary (0-12)   College (1-4or 5+)	chanic			Freight	Trucks	
Maryland 21215-0036	uld be file Mental Hy rrked othe ric event,		17. Father's Name (First, Middle, Last) Floyd Tressler		18. Mother's Name ( Anna Ma		•		
_	ロモレモ		Anna Mae Tressler/Mother 300 S	South Mont	and Number or Rural Valla Ave	., Hage	erstown, M	D 21740	
	permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other		4 Donation 5 Other (Specify)	position (Name of rematory or other pla Sh. Vetera	ns 04/11	/08 H	20c. Location - City or ${\tt furlock}$ ,	Maryland	
	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee  Wilhard 7. Gskur 2	22. Name and Addre 216 N. Mai	ess of Facility Fran In St., Fed	nptom F eralsbu	uneral Homurg, MD 216	ne, P.A. 632	
	Physician /Medical	Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A BLATERAL Control of the control of the cause		ng, such as cardiac or			Approximate Interval Between Onset and Death	
à	Examiner		ISCHEMIC COLON, Abdominal Compartment Sindrome						
	sit ed		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.  Infacted Acrts b. Lemmal GRAFT						
	execution and al-tran		Cause (Disease or injury that initiated events resulting in death) Last  C. Infecteck Acrts b. felmoral GRAFT  Due to (or as a consequence of):						
68760,	icate be executed physician and s the burial-transit		d						
	sertifica ding ph		IF FEMALE: 23c. If yes, outcome pf pregnancy				001.01.61		
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit		in the past 12 months?  1 Live birth 2 Fetal death 3	B □Ectopic pregnand D □ Other (specify) _	у		23d. Date of de Month	Day Year	
<u>a</u>	res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the		ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?	
Sign	w require been sig should b	ted b	Rend Artery Obstruction : Alcohol depends	ence. Hypert	enson,	1 🗆 Y	es 2 No 3 P	robably 4 Unknown	
I Records,	sician: The law r certificate has be irector, page 2 sh	Completed	Canotid stemosis			24a. Was a autops perfori 1∐ Yes	sy prior to	utopsy findings available completion of cause of	
Vital	ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:	Ot	26. Place of Death	Check only on	ne)		
0	Physer this eral dir	٦.	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Inju	4 Li Nursing Hom		ence 6 Other (Special Communication of the Communic	ecify)	
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	M 1	Yes 2□No	f. Location (Si City or Town	treet and Number or F	lural Route Number,	
۵	oltal or urs afte eral Dir illed in			- 41	in data and place				
	e Hos 24 ho e Fund detely f	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.						
	To the To the County	Me	29b. Signature and title of certifier	29c. Licens		2	9d. Date signed (Mon	th, Day, Year)	
)					18239		04 0	4 2005	
			30. Name and address of person who completed cause of death (Item 23a) (Type MAYUR WIRAY AN 22 SOUTH)		EET BALTIM	ORE, MD	21201		
	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 0 2008	and p					

DHMH 17 Rev 1/2001

RS 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 3:25 PM WELDON **Physician** MAE 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICR 10m6 NUVSING If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Days 1□M 2/1F 63 213-42-1466 MO. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No FREDERICK FREDERICK MD. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA BENTZ 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ Ze No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC FAMILIES 12 TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BOWIE WESL  $\subset$ . MARIAN L. SPENCER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LONG PINE PLACE ADT 10 BALT, MD. 21224 NICOLE R. WEEDON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State APRILS, 2008 SMITHEBURG, MD. SMITITISBURG 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. Home 21. Signature of Funeral Service Licensee olleis WEST SOUTH ST PREDERICR MO 21701 rang d. 110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or firjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown HYPERCAPHETC RESPIRATORY FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No SLOROSIS MULTIPLE 1□ Yes DIABETES 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending Investigation 1 Natural 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/nanner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Ú

PO BOX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CM APR 0 4 2008

RICHARD L-GOUGH

31. Date filed (Month, Day,

D32171

WALKORSUILLE MD

3/08

21793

		Please Type or Pr				Ensure A		•	
		For State Of W	nai yiai i		rtificate of		,	Reg. No. 🗥 🖺 🕦	0 10500
Physici	an	Decedent's Name (First, Middle, Last)     DAVID MITCHELL WOLK					2. Date of Dea Month	ath Day Year	3. Time of Death 10:39 AM
/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Death		March_	4c. County of Dea	ath	
Funeral Director	3	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$					8. Date of Birth (Month, Pay June 9,	Frederick  8. Date of Birth June 9,1956  Frederick  9. Birthplace (State or Follow) Washington,	
faryland show ed at	or	Usual Residence of Decedent		y, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th the Nor 28a-f	Director	10e. Street and Number	11	iu i iion	10f. Zip Code			10g. Citizen of What C	I I
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Iniportant: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	4 Stone Chapel Way  11. Marital Status  1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced  1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? ₹No		21788 Was Decedent of H If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- b Rican, etc.)	0	
72 hor	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup	pation during most of world)	king	16b. Kind of Business	s/Industry
within iene. r than	Completed	Elementary/Secondary (0-12) College (1-4ol	r 5+)		al Worke			US Post 0	ffice
e filed al Hyg I other	To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
hould to d Ment marked matic e		Joe Woll  19a. Informant's Name/Relationship (Type. Print)	lk	10h Mailie	ng Addrone /Street	Marion	ral Pauta Alumba	San er, City or Town, State,	ders
ind 2 si alth an 27 is r		Joe Wolk/ Father		1	ast Schu		ver Spr		21p Code) 0901
Pages 1 a lent of Hea nt: If Item ry or othe	Ī	20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	e	lace of Dispo emetery, crei	esition (Name of matory or other place Mem. Park	ce)	Date	20c. Location - City o	r Town, State
permit. Departm Importa any inju		21. Signature of Funeral Service Lipetises		- 1		ss of Facility St	auffer F	uneral Hom	•
40260	-	23a. 14 rt1. Enlar he disease, a complications that cause	ed the death					derick, Md	Approximate
Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or a		uence of):	ery dis	ease nelli	1.0		Interval Between Onset and Death
oe executed cian and ourial-transit	Examiner	riarly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
icate be exe physician a s the burial-	-10	Due to (or a d	is a consequ	uence of):					
The law requires that the death certificate be ate has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	y		23d. Date of do Month	elivery Day Year
equires that	ρ	Part II. Other significant conditions contributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.		bacco use contribute 'es 2 No 3 F	to the cause of death? Probably 4 Unknown
: The law re cate has be	Completed	high duolesterol					24a. Was a autop perfor 1 Yes	sy prior to	
/sician	o Be	25. Was case referred to medical examiner?  1  Yes 2 No							
nding Phy th. r: After this e funeral c	tion: To	27. Manner leath  Natural 5 Pending (Month, D		28b. Time o Injury	f 28c. Injur Wor	y at k? Yes 2 ☐ No		ow injury occurred	ecny)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 28e. Place of in	njury - At ho etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or F rn, State)	Rural Route Number,
ne Hospit n 24 houn he Funera pletely fille	edical (	29a. Certifier (Check only one) Certifying Physician: To the beside and manners and manners	of examinat	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To t with. To t	M	29b. Signature and title of certifier	1/1	-3	29c. Licens	53 12	-9	29d. Date signed (Mor	oth, Day, Year)
7		30. Name and address of person who completed cause of	death (Item	23a) (Type,	Print) Solare	x ct	frede	rick mi	21703
Sta Registr		31. Date filed (Month, Day, Year) 32. Regis APR 0 3 2008	strar's Signal	ture	forth	,			
HMH 17 Rev 1/20	001								

			For 1. State	State of Maryla	nd / Depa	artment of H	ealth and N			η Ω	12600
			Registrar		Ce	rtificate of L	Jeath		eg. No. 💛 🖰	J U	2 Time of Dooth
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Yeer	3. Time of Death
	/Medi	cal	Maria Consolat			T. 2. 2		03		2008 ty of Death	6:35 P
	Examir	ner	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or					
			27 Weber Road  5. Social Security Number 6. Sex	7 Age (In ves	s. last birthday)	0ak	Land If Under 24 Hrs.	8. Date of Birth	Garı		place (State or Foreign
	Funeral Director		218-80-6160	X 7. Age (In yrs		Months Days	Hours Min.	(Month, Day, 09-18-1		Cou	ntry) oit Michiga
			Usuel Residence of Decedent	/-	,	l		1 09-10-1	934		
o e la	Mot		10a. State 10b. County	10c. C	ity, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Ma	- 6 - 8 - 8 - 8 - 8	to	MD Garrett		Vakiai						1 Li Yes 2 Li No
Ę	within 72 nours atlet death with the Maryland ene. Then "neturel", or liems 23a or 28e-f show he Madical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of		ntry?
3	23a		27 Weber Road			21550				5.A.	
9	SE E	Funeral	11. Waltar Olatos	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Ha	ace - Ameri aek White	ican Indian, , etc.
36	2	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Spec		
	E E	d be	15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Ir	ndustry
रं दे	piene. r then "netu	Completed	(Specify only highest grade	e completed)	(Give	kind of work done of DO NOT use retired	furing most of wor				,
12	Hygiene. other ther	E	Elementary/Secondary (0-12)	College (1-4or 5+)	]	Disabled			Dia	sable	i
Maryland 21215-0036	F E E		17. Father's Name (First, Middle, Last)		1		18. Mother's Nan	ne (First, Middle, I	Maiden Suma	ime)	
an a		To Be	John David Weitz				Mati	lda Wei	tz		
7		-	19a. Informant's Name/Relationship (Ty	rpe, Print)		ng Address (Street a					p Code)
6	27 1 27 Ire		Linda DeWitt / I	Friend	27 W	eber Road	, Oaklan	d MD.	2155	U	
ē, 5	Department of Health Importent: If item 27 I any injury or other tre		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other plac	e)	Date	20c. Location	- City or T	own, State
DE SE	nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 1 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•	r & Paul	1	2/2008	Cumber	land,	Md
Baltimore,	partir porte porte / inju		21. Signature of Juneral Junes			2. Name and Address	s of Facility	ewart Fu	naral	Ноте	
m a	20 5 8		Wm H Ane	dochat	3	2.s.Secon	d Street	Oaklan	A MD		0
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de ne cause on each line.	ath. De not en	er the mode of dying	g, such as cardiad	or respiratory arro	est,		Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	Atherosc1	eroti	c cardi	ovascul	ar dise	ase		5 yrs
			resulting in death)	Due to (or as a conse							
н		ē	Sequentially list conditions,	Due to (or as a conse	adhence of).						
2		- Pe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Bading to immediate Enter Underlying Disease or injury							
	and I-trar	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
760,	sician and burial-transit	calE									
	<u> </u>			d							
Records, P.O. Box 68	attending physic	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg	nancy					ate of deliv	very
Вох	atter for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			!	Month Day Year	
o }	by the tached	ysi	1 ☐ Yes 22 No 9 ☐ Unknown	9☐Unknown		., ,,					
<b>ت</b> ق	deta		Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	inderlying cause give	en in Part I.	23e. Did tol	bacco use co	ntribute to	the cause of death?
sp.	sign ad bl	d by						1 □ Y	es 2∱∑No	3 🔲 Pro	babiy 4 Unknown
00	been si	Completed						24a. Was a	n 24b	. Were aut	opsy findings available
B B	page 2	Ĕ						autops	ned?	death?	ompletion of cause of
<u>a</u>		S	25. Was case referred to medical		<del> </del>		26 Place of Dec	1 ☐ Yes :	2 No	1 Li Yes	2 No
of Vita	is certific	8	avaminar?	Hospital:	☐ ER/Outpatie	nt 3□ DOA Othe	ar	ome 5- Reside		ther (Soec	ifv)
o a		۲۰ <u>۲</u>	27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time o	f 28c. Injun	/ at	28d. Describe ho			-97
Ou	th: After funer	to to	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury	M 1 🗆	(? Yes 2 □ No				
Division of Vital Records,	after death. Director: A	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st	reet, factory, office		28f. Location (Si City or Town	reet and Nur	nber or Ru	ral Route Number,
in it	Dire	Certification:	4 Homicide	building, etc. (Spec	ony)			City of Yow	i, State)		
Hoenitel	within 24 hours after de To the Funeral Direct completely filled in by th		29a. Certifier Certifying Phy (Check only 2 Medicel Exemi	sician: To the best of my k	nowledge, deal	h occurred at the tin	ne, date and place	, and due to the c	ause(s) and r	manner as	stated.
1	n 24 he F	Medical	one)	and manner stated.	nation and/or ii						
,	within 2 To the complet	Σ	29b. Signature and title of certifier	LIL		29c. License		2	9d. Date sign		
•			I finala	1 college	0)	D300	35		03-33	L – Z U (	70
		2	30. Name and address of person who con Donald R Richte	ompleted cause of death (It	em 23a) (Type, 533 Me	Print) morial	Drive 0	akland,	MD 2	21550	)
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	0		<u></u>			
	Regist	rar	APR - 2 21	JUD KARRED	DE R	souls!					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time-of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 16:15 PM **Physician** 2008 13 Kathleen E. Berryman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agus 5. Social Security Number n/a HOS DIE91 Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2**X** F 49 Nov 30, 1958 212-82-9708 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh notlfied a 1XYes 2 No Director Baltimore Maryland n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be I 21227 United States 23a 3300 Benson Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If then 27 is marked other thermany injury or other trainmany. 14 Race - American Indian · Items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Creighton J. Berryman Marie D. Hammond . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1119 Heaps Road, Street, Maryland 21154 Andrew J. Berryman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 KI Cremation 3 ☐ Bernoval from State 04/15/2008 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. St nature of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain Hematoma Bilateral EPidural **Physician** 2 day /Medical Due to (or as a consequence of): Popoteremia with sepsis Examiner Positive Cocci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Tyes 2 No 3 Probably Dectension 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Seizuro autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar KWAME

31. Date filed (Month, Day, Year) 2008 APR 18

NTIM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MEDICAL DOCTOR

Kathleen

Berryman,

P20805

# BRADLEY ames,

W.
8760
30x 6
.O.
ecords, F
Vital Ro
or
ivision

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James Bradley 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHarlE IVISTA MEDICAL C 8. Date of Birth Jan. 13 1943 Birthplace (State or Foreign Country)
 PA Age (In vrs. last birthday) Social Security Number **Funeral** Days 1 ☑ M 2 ☐ F Hours Months 166-34-0190 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygene. Important: If them 21 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 1 ☐Yes 2 ☐ No Philadelphia Director Philadelphia 10g. Citizen of What Country? 10e. Street and Number 19134 USA 2636 Livingston Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Labor Machinest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BradleySr. Teresa Μ. Egan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2749 Whispering Trails Dr. Winter Haven, FL 33884 James W. Bradley 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 2008 21 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Crematory Philadelphia, PA 4 Donation 5 Dother (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARNAC RROSET **Physician** \* Weins disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SPATING ENTESTEN M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ItEPATEC ENCRPALUPATI death certificate be executed y physician and as the burial-trans Due to (or as a consequence of): Physician/Medical as the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has | autopsy performed certificate 2□ No 2 No 1 ☐ Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Type, Print) of person who completed cause of death (Item 235) H. NAthen PemBrooks Square suite 103 Walder F. MD20603 GOTGE H. W. 31. Date filed (Month, Day, Year) State APR 18 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2008 Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryboul medical Center Bultimore University If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 ☐ F 241-40-6235 Director 10-11-1928 N.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at XXYes 2□No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 2522 W. Baltimore Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: <u>≨</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) A. Jacks Foundry Construction Worker 10th grade other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event Be Rosa Wooded- Brown Frank Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD\_21225 Brown - Wife 1001 Bethune Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Zion Cemetery 4-19-2008 Lansdown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 March F/H East I and wane Avenue Baltimore, MD 1101 Ε. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FYLLAS **Physician** 5 chemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? for 4 Pregnant at time of death signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 | Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 impatient 2 ☐ ER/Outpatient 3□ DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2

State Registrar 31. Date filed (Month, Day, Year)

APR 1 8 2008

Struit

Boom N3EOG Baltimore, Maryland 2(20)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar		Maryland / Dep <i>Ce</i>	ertificate of Death	·	Reg. No. 2008	12504	
·		1. Decedent's Name (First, Midd.	le, Last)			2. Date of De Month	eath Day Year	3. Time of Death	
Physic /Med		Nov	rella Elo	oise	Bittinger	April		2:30 P M	
Exam		4a. Facility Name (If not institution			4b. City, Town, or Location of	of Death	4c. County of Death		
		907 South Pot	omac Stree	t	Baltimore C	City	N/A		
Funera	1	5. Social Security Number		Age (In yrs. last birthday	If Under 1 Year   If Under 2   Months Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D	rth 9. Birthp	lace (State or Foreign	
Directo		214-24-0833	1□M 2X1F	80 Yrs.	Moritis Days Hours	Aug.	31,1927 Mary	land	
D		Usual Residence of Decedent							
rylar	_	10a. State 10b. County	1	10c. City, Town or L	ocation		1	0d. Inside City Limits	
a-f.s	응	Maryland N	I/A		Baltimore C	ity		1 X Yes 2 No	
th the	Ë	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cour	itry?	
5-0036 72 hours after death with the Maryland natural", or Items 23a or 28a-f show alcal Expuritive result be notified at	Funeral Director	907 South Pot	omac Street	5	212	24	United Stat	tes	
ems	ne l	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or No. Puerto Rican, etc.)	14. Race - Americ Black, White,		
after or It		1 ☐ Never Married 2 ☐ Mar	If Yes, Give	No I	1 □Yes ŽI□No Specify:	,			
21215-0036 d within 72 hours aft giene. er than "natural", or the Medical Exprini	Completed by	3,∰Widowed 4 □ Divorced	Year or Date	es:			Specify. White		
5-C	ete	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dece	edent's Usual Occupation e kind of work done during most DO NOT use retired)	t of working	16b. Kind of Business/Inc	dustry	
within iene.	臣	Elementary/Secondary (0-12)	College (1-4	Or 5+)					
d 21 filed w Hygie other ti	ပြ	7 Years		<u>H</u>	<u>Homemaker</u>	1 N (Final Mainle	Own Home		
ryland 2 rould be filed v fould be filed v found be filed	Be	17. Father's Name (First, Middle,	, Last)			er's Name (First, Middle			
aryla should the	မ	Harry L. Boyc	;e			ellie M. De			
Maryland nd 2 should be file tith and Mental Hy 27 Is marked oth		19a. Informant's Name/Relations			ling Address (Street and Numbe Nollmeyer Road				
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mast be notified at		Robert W. Bit	tinger (Son						
ges 1 and of Hee	1	20a. Method of Disposition  XX Burial 2 ☐ Cremation	3 ☐ Bernoval from St.		position (Name of ematory or other place)	Date	20c. Location - City or To	_	
Pages ment of ant: If its ury or o		Donation 5 Other (S		Gardens	of Faith Cem	4/14/2008	Baltimore,	Maryland	
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe		21. Sign of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
		23a. Part1, Enter the disease, o	fr complications that cau	ised the death. Do not er				Approximate Interval Between	
		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on eac	th lin	00000 000000 44400 2040		63	Interval Between Onset and Death	
Physician /Medica		disease or condition resulting in death)	a	CANGION	ug apring				
Examine			Due to (or	as a consequence of):	V ALUE D.	-Arex	Li Stude		
	<u>-</u>	Section tially fist conditions	b. Due to (or	as a consequence of):	1 10002 17:1	, , ,	77 -0713		
rted nsit	Ξ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	C	Dans A.T.	no Prose	26 .		
exect	Examiner	resulting in death) Last	c Due to (or	as a consequence of):	Tru-	( ( ( )			
18760, icate be executed physician and the burial-transit	<u>e</u>			HIDSR.	de colum				
2 5 0	edical		0	1 1 1 2 2					
					C. A O.				
	N N	IF FEMALE:	23c. If yes, outco	ome of pregnancy			23d Date of deliv	erv	
	cian/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 🗆 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year	
	ysician/Me	23b. Was decedent pregnant	1 ☐ Live bir	th 2 Fetal death 3 nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)				
	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ 10	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)	. 23e. Did		Day Year	
	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)		Month	Day Year he cause of death?	
	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)	1	Month  tobacco use contribute to t	Day Year the cause of death? bably 4 □ Unknown	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)	1	Month  tobacco use contribute to t   Yes 2  No 3 Prol   Pr	Day Year he cause of death?	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)	1	Month  tobacco use contribute to t  Yes 2 No 3 Prol s an 24b. Were auto prior to co death?	Day Year  he cause of death?  bably 4 □ Unknown  posy findings available impletion of cause of	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	ions contributing to dear	th 2 Petal death 3 nt at time of death 5 vn	Other (specify)  underlying cause given in Part I.	1	Month  tobacco use contribute to t  Yes 2 No 3 Prol s an 24b. Were auto prior to co death? No 1 Yes	Day Year  he cause of death?  bably 4 □ Unknown  posy findings available impletion of cause of	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2  9 □ Unknown  Part II. Other significant condit  25. Was case referred to medical examiner?  1 □ Yes 2	ions contributing to deat  Hospital:  1 Live bir 4 Pregna 9 Unknov	th 2 Fetal death 3 nt at time of death 5 vn  th but not resulting in the continuous cont	Other (specify)  underlying cause given in Part I.  26. Place	24a. Wa autroper 1 1 Yes of Death (Check only ursing Home	Month  tobacco use contribute to t  Yes 2 No 3 Prol  s an ppsy Prior to co death? 1 Yes one)  sidence 6 Other (Special Control of the Control	he cause of death?  bably 4 Unknown  opsy findings available mpletion of cause of  2 No	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	ions contributing to deal  Hospital:  1   Inp.  28a. Date of	th 2 Fetal death 3 nt at time of death 5 vn  th but not resulting in the continuous cont	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ Nu of 28c. Injury at Work?	24a. Wa autoper 1 Tyes e of Death (Check only ursing Home 28d Describe	Month  tobacco use contribute to t   Yes 2  No 3 Prol  S an ppsy   24b. Were autorior to content of the content	he cause of death?  bably 4 Unknown  opsy findings available mpletion of cause of  2 No	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2	ions contributing to dear  Hospital: 1   Inp.  28a. Date of (Month, ligation)	th 2 Fetal death 3 nt at time of death 5 vn  th but not resulting in the state of t	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ NL of 28c. Injury at Work? M 1 □ Yes 2 □	24a. Wa autoper 1 Tyes e of Death (Check only ursing Home 28d Describe	Month  tobacco use contribute to t  Yes 2 No 3 Prol  s an ppsy Prior to co death? 1 Yes one)  sidence 6 Other (Special Control of the Control	he cause of death?  bably 4 Unknown  opsy findings available mpletion of cause of  2 No	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	ions contributing to dear  Hospital: 1   Inp.  28a. Date of (Month, ligation)	th 2 Fetal death 3 nt at time of death 5 vn  th but not resulting in the continuous cont	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ NL of 28c. Injury at Work? M 1 □ Yes 2 □	24a. Wa autroper 1 Tyes e of Death (Check only ursing Home 28d Describe	Month  tobacco use contribute to t  Yes 2 No 3 Prol  s an ppsy Prior to co death? 1 Yes one)  sidence 6 Other (Special Control of the Control	Day Year  the cause of death?  bably 4 □ Unknown  opsy findings available impletion of cause of  2 □ No	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   You want to be presented to medical examiner?  1   Yes 2   You want want want want want want want want	al Hospital: 1 In Ing. 28a. Date of (Month, ligation Inot be mined 28e. Place of building	th 2 Fetal death 3 nt at time of death 5 yrn  th but not resulting in the state of	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ Nu of 28c. Injury at Work? M 1 □ Yes 2 □ treet, factory, office	24a. Wa autroper 1 Tyes e of Death (Check only ursing Home 28d Describe	Month  tobacco use contribute to t  Yes 2 No 3 Prol  s an ppsy 24b. Were autor prior to conce death?  2 No 1 Yes  one)  sidence 6 Other (Special Property of the control of	Day Year  the cause of death?  bably 4 □ Unknown  posy findings available impletion of cause of 2 □ No  fy)  al Route Number,	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   Yo 9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner?  1   Yes 2   Yo    27. Manner of Death  1   Matural   5   Pendi   2   Accident   3   Suicide   6   Could   4   Homicide      29a. Certifier   TS Certifying	ions contributing to deal  Hospital:  1	th 2 Fetal death 3 nt at time of death 5 yn  th but not resulting in the location 2 ER/Outpatic Injury Day, Year)  est of my knowledge, deals of examination and/or	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ NL of 28c. Injury at Work? M 1 □ Yes 2 □	24a. Wa autopering to the pering to the peri	Month  tobacco use contribute to to to tobacco use contribute to to tobacco use contribute to to tobacco use and set of tobacco use contribute to to to tobacco use contribute to to tobacco use contribute to to tobacco use contribute to to to tobacco use contribute to to to tobacco use contribute to tobacco use contribute to to tobacco use contribute to to tobacco use contribute to toba	he cause of death?  bably 4 Unknown  possy findings available mpletion of cause of 2 No  fy)  al Route Number,	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   Yo 9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death 1   Vatural   5   Pendi invest   3   Suicide   4   Homicide   4   Homicide   4   Medical   4   Medical	al Hospital: 1 Ing Ing Ing Physician: To the bas and manne	th 2 Fetal death 3 nt at time of death 5 yn  th but not resulting in the location 2 ER/Outpatic Injury Day, Year)  est of my knowledge, deals of examination and/or	Other (specify)  underlying cause given in Part I.  26. Place ent 3 DOA Other: 4 NL of 28c. Injury at Work? M 1 Yes 2   street, factory, office  ath occurred at the time, date ar investigation, in my opinion, deal	24a. Wa autoper 1   24a. Wa autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 25a.	Month  tobacco use contribute to to to tobacco use contribute to to tobacco use contribute to to tobacco use and set of tobacco use contribute to to to tobacco use contribute to to tobacco use contribute to to tobacco use contribute to to to tobacco use contribute to to to tobacco use contribute to tobacco use contribute to to tobacco use contribute to to tobacco use contribute to toba	he cause of death?  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of  2 No  fy)  al Route Number,  stated.  o the cause(s)	
P.O. Box 6 hat the death certificted by the attending letached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Matural   5   Pendi   2   Accident   3   Suicide   4   Homicide    29a. Certifier (Check only one)	al Hospital: 1 Ing Ing Ing Physician: To the bas and manne	th 2 Fetal death 3 nt at time of death 5 yn  th but not resulting in the location 2 ER/Outpatic Injury Day, Year)  est of my knowledge, deals of examination and/or	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ NL of 28c. Injury at Work? M 1 □ Yes 2 □ attreet, factory, office  ath occurred at the time, date ar investigation, in my opinion, dec	24a. Wa autoper 1   24a. Wa autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 25a.	Month  tobacco use contribute to to to tobacco use contribute to to tobacco use contribute to to tobacco use and prior to condeath?  1   Yes   24b. Were autor prior to condeath? 1   Yes   1	he cause of death?  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of  2 No  fy)  al Route Number,  stated.  o the cause(s)	
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death certif- within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death 1   Accident   5   Pendi invest   3   Suicide   4   Homicide    29a. Certifier (Check only one)  29b. Signature and title of certification   1   1   1   1   1   1   1   1   1	al Hospital: 1 In Ing.  28a. Date of (Month, it is in the base and manneer.)	th 2 Fetal death 3 nt at time of death 5 yrn  th but not resulting in the state of	Other (specify)  underlying cause given in Part I.  26. Place ent 3 □ DOA Other: 4 □ Nu of 28c. Injury at Work? M 1 □ Yes 2 □  street, factory, office  ath occurred at the time, date ar investigation, in my opinion, dea	24a. Wa autoper 1	Month  tobacco use contribute to total  Yes 2 No 3 Prol  s an ppsy 24b. Were autor prior to conce death? 1 Yes  one)  sidence 6 Other (Special how injury occurred  (Street and Number or Run  wan, State)  e cause(s) and manner as and death and place, and due to 29d. Date signed (Month,	he cause of death?  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of  2 No  fy)  al Route Number,  stated.  o the cause(s)	
ecords, P.O. Box 6 aw requires that the death certif as been signed by the attending 2 should be detached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Matural   5   Pendi   2   Accident   3   Suicide   4   Homicide    29a. Certifier (Check only one)	al Hospital: 1 Ingline Ingline Ing Physician: To the base and manne	th 2 Fetal death 3 nt at time of death 5 yrn  th but not resulting in the state of	26. Place ent 3 DOA Other: 4 NL of 28c. Injury at Work? M 1 Yes 2 Determined the time, date are investigation, in my opinion, decay.	24a. Wa autoper 1   24a. Wa autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 24a. Was autoper 25a.	Month  tobacco use contribute to total  Yes 2 No 3 Prol  s an ppsy 24b. Were autor prior to conce death? 1 Yes  one)  sidence 6 Other (Special how injury occurred  (Street and Number or Run  wan, State)  e cause(s) and manner as and death and place, and due to 29d. Date signed (Month,	he cause of death?  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of  2 No  fy)  al Route Number,  stated.  o the cause(s)	
To the Hospital or Attending Physician: The law requires that the death certifully also the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death 1   Accident   5   Pendi invest   3   Suicide   4   Homicide    29a. Certifier (Check only one)  29b. Signature and title of certification   20   Medical   20	ions contributing to deal  Hospital: 1 Ing 28a. Date of (Month, ligation) I not be mined 28e. Place of building Ing Physician: To the bas and manne  er who completed cause M. D. 2801	th 2 Fetal death and at time of death 5 yrn  th but not resulting in the state of t	Other (specify)  underlying cause given in Part I.  26. Place ent 3 DOA Other: 4 NL of 28c. Injury at Work? M 1 Yes 2 Detection of the coursed at the time, date an investigation, in my opinion, deal and investigation. The course number O CYC.  29c. License number O CYC. entropy of the course of	24a. Wa autoper 1	Month  tobacco use contribute to total  Yes 2 No 3 Prol  s an ppsy 24b. Were autor prior to conce death? 1 Yes  one)  sidence 6 Other (Special how injury occurred  (Street and Number or Run  wan, State)  e cause(s) and manner as and death and place, and due to 29d. Date signed (Month,	he cause of death?  he cause of death?  bably 4 □ Unknown  possy findings available impletion of cause of 2 □ No  fy)  al Route Number,  stated. o the cause(s)  Day, Year)	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 16, 7:00AM Julia Pearle Bremerman April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3100 N. Leisure World Boulevard #309 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Months Days Hours Min. November 30, 1918 Director 215-05-7875 89 Maryland Usual Residence of Decedent 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 10a State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2X No Silver Spring Marvland Montgomery the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3100 N. Leisure World Boulevard #309 20906 United States Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify. þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important; If Item 27 is marked other I any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Benjamin A. Burroughs Alice P. Butt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3100 N. Leisure World Boulevard #1008
Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type. Print) Robert L. Bremerman/ Son Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 ▼Other (Specify) Entombment of Heaven Mausoleum 20a. Method of Disposition Date 20c. Location - City or Town, State April en Mausoleum 21, 2008 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Fumphrey Funeral Rome/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Silver Spring, Maryland 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Renal Insufficiency and burial-trar Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🕅 No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.0. detached 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has page 2 autopsy performed? 1 Yes 2 K No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 1 🕅 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Sharon Yang, M.D. 3305 N. Leisure World Boulevard, Silver Spring, Maryland 20906 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2008 Registrar

			For State Registrar	State of Marylan	-	nt of Health and te of Death		ene 008	12606
			Decedent's Name (First, Middle, Last	t)	<i>C</i> ,		2. Date of Death		3. Time of Death
	Physici /Medio		Gra	ce	Crab.	11	April	14 2008	12:40P.M
)	Examin	er	4a. Facility Name (If not institution, give		4b. Cit	, Town, or Location of Deat	2	4c. County of Death	
-	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		er 1 Year If Under 24 Hrs		Partor 9. Birth	nplace (State or Foreign
	Director		0113 70- 3000	□M 200 F	64 rs. Months	B Days Hours Min.	Month, Day,		sylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
	a-f sh	ctor	PA York		De	Ita			1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	. 0 1	10f. Z	ip Code	10	g. Citizen of What Co	4
	death with the Maryland ms 23a or 28a-f show Linual be notilised at	erai	5 42 (old (ol) 11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Dec	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	ncan Indian,
9	or item	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give	If Yes, sp 1 ☐ Yes	ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
21215-0036	within 72 hours after then "natural", or ite the Madical Examina	d by	3 Widowed 4 □ Divorced	Year or Dates:				Specify: W	hite
15	nin 72 n nat	piete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Us (Give kind of k life. DO NOT	ork done during most of wo	rking	6b. Kind of Business/l	naustry
212	filed with Hygiene Ither tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fabric.	Designer		Self-Emple	yed Owner
and	8 g s	Be	17. Father's Name (First, Middle, Last)	Tolinas		4 / -	me (First, Middle, M	laiden Surname)	,
Maryland	should I nd Ment market	ဥ	19a. Informant's Name/Relationship (1	y dings.	19b. Mailing Addre	ss (Street and Number or Ri		(I) City or Town, State, 2	ip Code)
	end 2 patth a n 27 is er trac		Bonita Richa	dson-Daught	3735 A	wis Corner	Kd. Str	eet MA	21154
Baltimore	ges 1 t of He if iten or oth		20a. Method of Disposition 1	Removal from State	Place of Disposition (Nometery, crematory of	ame of other place)	Date 2	Oc. Location - City or	Town, State
턡	t. Pa rtr er rtent ajury	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Ucen	000		and Address of Faculty	1-18-08	Micottle	ty, MI)
Ba	Departiment Department		Kimboll	Mulotan	Fundsi	3 De port	1-07e	tion Selvic	41 21050.
i			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the deat	th. Do not enter the mo	ode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
Š.	Physician		Immediate Cause (Final disease or condition			sowel !			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	A .	1 2 2	6 10		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq		ocardial in	HELCHON	)	
V	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	ate be executed hysicien and the burial-transit	al E	rosaming in ocally cast	Due to (or as a conseq	(uence of):				
687	ificate g phys as the	edical		d					1000m
Вох	Attanding Physician: The law requires that the death certific r death. c death. ector: After this certificate has been signed by the attending p bot the funeral director, page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of deli Month	very Day Year
P.O.	he des	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	ieath 5□ Other (	specify)		World	Day Tear
	res that igned by	y Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	w require been sig should b	ted t	Severe	COPD			1 ☐ Ye	s 2 No 3 Pr	obably 4 Unknown
ecc	e lawr has be ge 2 sh	npie					24a. Was an autopsy perform	24b. Were au prior to d	topsy findings available completion of cause of
alF	n: Thi ficate or, pag		OF Man annu referred to medical				1□ Yes 2	☑No 1☐Yes	2 No
ž	ysicia s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ [	Other	ath <i>(Check only one</i> Home 5 ☐ Resider	nce 6 ⊟Other (Spec	zifv)
Division of Vital Records,	ng Ph Iter thi		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		,
Sio	ttsndi death. tor: A the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M	1 ☐ Yes 2 ☐ No	201 Location (Str	eet and Number or Ru	
	= = = =	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	fy)	ory, office	City or Town,	State)	rai Houte Number,
	To the Hospital or Attanding Physician: The lawithin 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	. F	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurre	d at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
	the H thin 24 the F mplete	Medical	29b. Signature/and title-of certifier	and manner stated.		9c. License number		d. Date signed (Monti	
	7 × 5 8	-	I fil film W	Lu. l	-	06342		1pril, 14, 2	*
	12		30. Name and address of person who						
	1 '		S. Zubai	r Kharal	501 S.	Union Aver	ive, Harr	re de Graci	e, MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	A Specia	>			
	3,		APR 1 8 2	108 Been	AS MINER				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Cerrato John -0015 Apri 5 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hillburn venue If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months 219-22-4475 tarch 25,192 Director Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director MD timore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 1-luenue within 72 hours after death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) completed) College (1-4or 5+) Elementary/Secondary (0-12) Johns Hookins 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H f item 27 is marked ott Be A Mary ဂ squale 19b. Mailing Address (Street and Number or Rura oute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21214 5407 Hillburn Jennis ( 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial

Park Cemeters Pages 1 a 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-19-08 4 Donation 5 Dother (Specify) 22. Name and Ad ess of Facility 21. Signature of Funeral Service Licenses chapel + Cremation Services Evans 8800 Harford Road Parkville Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: f yes, outcome pf pregnancy □ □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 1 Inpatient Certification: To 288. Describe how injury occurred 28a. Date of Injury 28b. Time of s after death. 27. Manner of 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. the 29c. License number 29b. Signature and titl 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Alexander LEE 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 740 North Pup) Antrove Street Apt. 26 BAltinors If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

3. Date of Birth (Month, Day, Year)

3. Date of Birth (State or Fore Country)

3. Date of Birth (Month) ( 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 □ F 214-50-0674 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at BAltimore 1. Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 740 North Poplar brove Street Apt. 26 21216 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK Maryland 21215-0036 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) ges 1 and 2 should be filed within it of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) BAHIMORE City School System 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) MARTHA PEAR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1647 Craftswood Road Catonsville MD T. CorbE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State April 19 2008 RANDANSTOWN MD 3436 W. Forest Park Ave. permit. Page Department o Important: If any Injury or KINGMEMONIAL PARK 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 21216 I Evroy C. DyEtt, Ir. Fundad Service & A. Batto MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY NOW- (SCHEMIC Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown ESSENTIAL 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check onl o e Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No N/A 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ALL 17, 2008 Mans dorwoony SECURITY BUSO BONTIMONE MO 21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 1 8 2008 State

DHMH 17 Rev 1/2001

Registrar

\*Core

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Howard James Clem, Jr. 5:45 A. 15 2008 April /Medical 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Charlotte Hall Veterans Home St. Marvs Charlotte Hall If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Date of Birth (Month, Day, Year) Months Days 1 X M 2 □ I Maryland 220 14 1633 81 Director 06/05/1926 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 9 - 9th Avenue 21225 U.S.A. Funeral ural", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
int: If item 27 Is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector General Motors 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard James Clem, Sr. 2 Mae E. DeMartello 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Clem, III / Son 9 - 9th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Department of Important: If any Injury or Glen Haven Mem. Park 04/18/2008 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature Funeral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, shock, or heart failure. Li cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No. 9 I Unknown s been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ALZHEIMERS 24a. Was an · has r page 2 autopsy performe 2 🗾 or Attending Physician; 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' 2 No Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 | Pending investigation 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Louis Kaufman 29449 Charlotte Hall Road Charlotte Hall, Maryland 20622 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2: 40 AM /Medical 4a\_Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** TIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 ☐ M 2 🔀 F Director 212-30-3313 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2300 CHELSEA TER 21216 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🗷 No þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Item Insury Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 9TH NURSING NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH PLUMMER 2 <u>GENEVA G. WILKINS</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRIE TURNER/DAUGHTER 3438 LYNNE HAVEN, DR., WINDSOR MILL, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 04/15/2008 PIKESVILLE, MD 21208 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensed 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the dise set, or compshock, or heart fail to. List only or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and I-tran. Due to (or as a consequence of) physician a s the burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. ned by the 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ∐Yes 2 MNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Marsing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Marmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) We ZIZA Biltonine Oth Defy Wors, Do 31. Date filed (Month, Day Year) 3. Registrar's Signature State APR 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death edent's Name 2. Date of Death **Physician** Month 15,2008 /Medical or Location of Death 4c. County of Death Examiner ltimore If Under 24 Hrs. Birthplace (State or Foreign Country) (In yrs. last birthday **Funeral** Hours Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits ms 23a or 28a-f shor MD 1 Xes 2 □ No Funeral Director Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Was Decedent Ever in U.S. Armed Forces? American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use setired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Moth Be ٥ Name/Relationship (Typ Rural Route Number, City or Town, State, Zip Code) Baltimore, InD 21207 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ortant: if i permit. Page Department o Important: if any Injury or 21. Signature of Funera Si Nat'l Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or he is the lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIAN CRUCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760 attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 00 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed?. Yes 2DKV 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 → 2 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 2 ER/Outpatient 3 DOA 6 XOUN ESTABLIS 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? after death. 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 5 To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated -trending 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 227 Ba 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lace 21202

Registrar

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:15 PM M 13 2008 Anna K. Dorsett 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Street, Maryland If Under 1 Year If Under 24 Hrs. Harford Hart Hertiage Estate Assisted Living Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Months Days Hours 86 10/19/1921 Maryland Director 220-14-5062 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Kingsville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21087 12320 Belair Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Farming Industry 8 Farmer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H ant; If Item 27 Is marked oth ပ္ Rose Zimmerer John Frederick Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) joyce B. Schwandtner (dtr.in Law) 12001 Belair Road - Kingsville, Maryland 21087 Department of Heal Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 04/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 co Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Consistive Hest Facture years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of) Box 68760 attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 2□ No certificate 1 TYes 1□ Yes 2 No ASSESTEA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 TYes 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Facility 27. Manner of Dea 28c. Injury at Work? Certification: (Month, Day Year) Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation within 24 hours arter com...

To the Funeral Director; Aff

To the Funeral Director; Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INCPHAIL BELDIN MA 21014 PRILLY DUFFRED 615 31. Date filed (Month, Day APR 1 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

			1 - For State Registrar		,	Cer	tificate of		omair	Reg. N	lo.	1 600	UI
	Physici	on.	1. Decedent's Name (First, Middle, La	st)				11-11-11-11	2. Date of I		Day Year	3. Time of I	Death
	/Medic		Mary V. Dav						April	11	, 2008	7:15	Рм
	Examin	ner	4a. Facility Name (If not institution, give		hah		4b. City, Town, o	r Location of Dea ckville	ath	4	c. County of Death  Montgome	rv	
.*	Funeral		Shady Grove Nurs  5. Social Security Number 6. 8		(In yrs. last bir	thday)	If Under 1 Year_	If Under 24 Hr	s. 8. Date of I	Birth	0	-	r Foreign
	Director		213-12-1358	1□M 2XIF 8	6	Yrs.	Months Days	Hours Mir	Septemb	er 24	9. Birthp Coun 1921 Mary	and	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	ortoc	ation				11	0d. Inside Cit	ry Limits
	Maryle f sho	ō	Maryland Montgo	merv			rson					1 ☐ Yes	-
	r 28a-	irec	10e. Street and Number	inc Ly			10f. Zip Code			10g. (	Citizen of What Coun	try?	
	23a o	Funeral Director	18520 Trundle Roa	ıd				20842		U	Inited Sta	tes	
	tems tems	nuel	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race - Americ Black, White, e		
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evanther rout be neitlied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 M N If Yes, Give Year or Dates:	lo	1	□Yes 2No	Specify:			Specify: W	Mite	
ŏ	2 hou	ted	15. Decedent's E	ducation	16a.	Deced	ent's Usual Occup	ation		16b.	Kind of Business/Inc	iustry	
21	ithin 7 ne. nan "n	Completed	(Specify only highest grade) Elementary/Secondary (0-12)	College (1-4or 5			kind of work done OO NOT use retired	during most of wi	orking		ited Stat	es	
22	lled w Hygiel ther th		12 17. Father's Name (First, Middle, Last	1	A	.cco	untant	19 Mother's No	ame (First, Midd		overnment		
and	d be f ental l ked ol	To Be	William B. Kelle						iia Jone		on Gumame)		
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship		19b	. Mailing	g Address (Street	and Number or I	Rural Route Nur	nber, City	y or Town, State, Zip	Code)	
Σ,	and 2 ealth a n 27 i		William I. Davis	/ Son					ickerso		aryland 20		
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. int: if item 27 is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, the Medical Evannian rosal be natified at any or other traumatic event, the Medical Evannian rosal be natified at		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State			sition (Name of atory or other place	, 4	il 16,		Location - City or To		
			4 □ Donation 5 □ Other (Special		Montgome	,	rematorium	1 200	800	1	thesda, Ma		
Ва	permit. Departr Importa any inja once.		21. Signally of Fundal Service-Lice	~	1305	Rob	ert A. Pun	phrey Fun	eral Home	/Rock	ville, Inc. e, Maryland	20850-2	2805
			23a. Part 1 Enter the disease, or com	plications that caused	the death. Do i						, , , , , , , , , , , , , , , , , , , ,	Approximate Interval Betv	€
· Y	Physician	βĤ	shock, or heart failure. List only Immediate Cause (Final disease or condition	Sepsi								Onset and D	eath
	/Medical		resulting in death)	Due to (or as	a consequence	of):							
F	Examiner	Ļ.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):										
/	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	The second secon	re to I		Ve						
<u></u>	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	C	a consequence		<u> </u>						
98/e0	death certificate be executed e attending physician and d for use as the burial-transit	Medical		d									
9	ertifica ling ph e as th	Med	IF FEMALE:										
X P P	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal déath		Ectopic pregnanc	у			23d. Date of delive Month		⁄ear
		Physician/	1 □Yes 2 🕅 No 9 □ Unknown	9 Unknown	une or death	الـ د	Other (specify) _			-			
ν, J	requires that the neen signed by th	by Pt	Part II. Other significant conditions	contributing to death bu	it not resulting in	the un	derlying cause giv	en in Part I.	23e. Di	d tobacc	o use contribute to th	ie cause of de	eath?
ğ	equire en sig ould b								_ 1[	Yes	2 No 3 Prob	ably 4 💢 U	Inknown
ပ္မ	law re nas be 2 sho	Completed							24a. W	topsy	24b. Were auto	psy findings a	available ause of
<u> </u>	sician: The law certificate has t irector, page 2 s	Com							pe 1 □Yes	rformed?	death? No 1 ☐ Yes	2	
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	nding Physician: th. : After this certifica ? funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:	_		_ Loth		eath (Check onl				
<u></u>	를 들는 기술	1: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injur	nt 2 ER/Ou	tpatient Fime of	28c. Injui				6 Other (Specification)	v)	
<u>.</u>	nding ath. r: Afte e fune	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	( <i>Month, Da</i> y n	(, Year) l	njury		ќ? Yes 2□No					
DIVISION	r Atte er dez rector	ertification:	3 Suicide 6 Could not be determined		ry - At home, fai . (Specify)	rm, stre	et, factory, office		28f. Location	(Street Town, Sta	and Number or Rura	l Route Numl	ber,
5	vital o urs aft ral Di	O	XZ.										
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		hysician: To the best of miner: On the basis of and manner sta	examination an								)
	Fo the within Fo the comple	Mec	29b. Signature and title of certifier	and marrier sta			29c. Licens	e number		29d. [	Date signed (Month,	Day, Year)	
			· Allo	\$19ml	MI		MD 5	5054		Ap	ril 15, 20	80(	
	3		30. Name and address of person who					"		•	75 - 4	1 000:	7 7
			Attan Kasid, M.D	. 604 Sout		cick	Avenue,	#409,	Gaither	sbur	g, Marylar	1d 208/	/ /
	Sta Registr		APR 1 8 2008	32. Hegistia	S A	234	وع						

DHMH 17 Rev 1/2001

MEND TTEM#4c,perPHYS. 7878,4/18708,ws State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ам 2008 04 6 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Specialt tospital ) viversit Birth Day, Year)

14, 1949

9. Birthplace (State or Foreign Country)

Country)

Pennsylvania If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F Months Days Hours Min. Director 215-50-8166 July Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 1 ☑ Yes 2 ☐ No Director Baltimore MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3715 Greenvale Road USA 21229 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" permit in injury or other traumatic events. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1969 – 1 12. Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 9 3 Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hame Construction Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Matthew Ellis Nancy Francis Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Ellis/ Sister 3921 Yolando Rd. Baltimore, MD. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/21/08 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) Chapel- Bel Air Evans Fune Land Chapel & Crematin Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee well 23a. Pa. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stylick, or heart to lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration prenmonia-/Medical Due to (or as a consequence of): Examiner Respiratory ventilator dependent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine law requires that the death certificate be executed Obstructive Untermona use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the s 1 Tyes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Piex 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2⊠No 1∐ Yes I or Attending Physician: after death. Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 200 No 1 Tyes 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 Tes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-16-2008 D0061882 5 Charles Street Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21230 141 601 Cordelia 31. Date filed (Month R 1 8 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		rtificate of			glene Reg. No. 200	8 12615
	Physici /Medic		1. Decedent's Name (First, Middle, Last James	Ellers				2. Date of Dea	,Day Y	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give  JGM5 Hopkins Bout  5. Social Security Number 6. Se	view Medical	(enter last birthday) Yrs.	4b. City, Town, o	r Location of Death  H'M C I  If Under 24 Hrs.  Hours Min.	8. Date of Birtl (Month, Day Apr 22	4c. County of y, Year) 9	Birthplace (State or Foreign Country) unk
	land ow it		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	e Mary ta-f sho tifled a	ctor	MD Baltimo	re	Dunda	lk				1 ☐ Yes 2√ No
	h with the 13a or 28 st be no	al Director	10e. Street and Number 201 Ash Avenue			10f. Zip Code	21222		10g. Citizen of Wha USA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2🌠 No	lispanic Origin? (S an, Mexican, Puert <i>Sp</i> ec <i>ity:</i>		Black, Specify: W	
21215-0036	filed within 72 h Hygiene. rther than "natu ant, the Medical	Completed	15. Decedent's Edit (Specify only highest grade)  Elementary/Secondary (0-12)  unk	cation le completed) College (1-4or 5+)	16a. Deced (Give life. I	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wor d)	<sub>king</sub> unk	16b. Kind of Busin	ess/Industry unl
<b>Maryland</b>	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	unk
Mary	12 shou h and M <b>is mar</b> raumat	-	19a. Informant's Name/Relationship (T						er, City or Town, Sta	
Baltimore, I	First Pa		Hopkins Bayview M  20a. Method of Disposition  1 Bunal 2 Cremation 3 C  4 Donation 5 Nother (Specify	20b. Removal from State		J Easterr sition (Name of matory or other pla	n AVenue	Date Date	20c. Location - Cit	1224 ry or Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Nade, Sirecto		Name and Address ate Anat Iltimore,	-		Baltimon	re Street
in it	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the dea ne cause on each line.  a. Arrhyth Due to (or as a conse	m/a quence of):	er the mode of dyi	ng, such as cardiad	c or respiratory ar	rest,	Approximate Interval Between Onset and Death Minutes
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of):	MIGIC .				10 days
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc	у		23d. Date of Month	
Δ.	w requires that s been signed b should be deta		Part II. Other significant conditions of	ontributing to death but not res	_		a a			ute to the cause of death?  ▼ Probably 4 □Unknown
or Vital Records,	The law recate has bee bage 2 shou	Completed by		<u> </u>	93			24a. Was autop perfo	osy prio ormed? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \sum \) No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or.	ath (Check only o	nne)	
100	ding Phys J. After this funeral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL OLI DOX	4 🗆 Nursing r		dence 6 Other how injury occurred	
Division	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, str	M 1 □	]Yes 2□No	28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce		vsician: To the best of my kn Iner: On the basis of examin and manner stated.						
	To the within To the comple	Med	29b. Signature and title of certifier			29c. Licens			29d. Date signed (	
			30. Name and address of person who	ompleted cause of death (Ite	om 23a) (Type,	Print)	0657	8	- 11.0	1 2008 ILAND 21224
13	Sta	ate	PACHEL DAMICO 31. Date filed (Month, Day, Year)	MD 4940 82. Registrar's Sign	LASTE nature	KIN AVE	UVE BA	CIMUYC	= MANU	LAND ULLY

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [11] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Morith 15 Barbara Engle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis If Under 1 Year | If Under 24 Hrs. Anne Arundel General Hospital Anne Arundel 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) Hours 1 □ M 2 □X Months Days III inois Director 348-26-0567 Nov.27. 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it e Madical Examination as be notified at 1 ☐ Yes 2 No Director Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 414 Edgewater Rd. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: 3 □XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing 12 Registered Nurse 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence D. Russell Ft.hel ٧. Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Gabriel (Daughter) 414 Edgewater Rd. Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Metro Crematory Inc.: 4/21/08 22. Name and Address of Facility Stallings Funeral Home PA 21. Signatu e or Funeral er de Lio ee 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or shock, or heart failure. List co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or is a consequence of): Examiner Neumon Sequentially list conditions, Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-transit L<sup>B</sup> Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 ANO signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate | 1 □ Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 11001

31. Date filed (Month, Day, Year)

APR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Signature

ORIGINAL

71				000100	, 110	773
State of Mar	yland / Departmer	it of Health	and Me	ental Hyd	iene	21

			1 = For State Registrar	Otato or mo	il ylalla /		rtificate of	Death	-	Reg. No.		k transp h <sub>al</sub> e # #
	Physic	an	1. Decedent's Name (First, Middle, L			_			2. Date of De	ath Day	Year	3. Time of Death
No.	/Medi	al	An English Name (15 and to 15 th	Charles	в М.	E	dwards	1	4	14 2	2008	3:43 a M
	Examir	er	4a. Facility Name (If not institution, g 415 Milford M					r Location of Death			inty of Death	
M.	Funeral Director		219-18-8375	Sex 7. Age 1 M 2 F	(In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 7-13	h y, Year) -1922	9. Birth Cou	place (State or Foreign ntry) MD
	/land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	ne Mary 8a-f sh atiffed	Director	MD	N/A	Pikes	vil	le					1 □Yes 2□No
	ath with the 2 s 23a or 2 lust be no	ral Dire	10e. Street and Number 415 Milford I				10f. Zip Code 2120			U S		
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tes 2 N If Yes, Giva X Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: B	
21215-0036	within 72 h iene. than "natu the Medical	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4or 5-	·)	(Give life.		ation during most of work d)	ing		side	Gardens
d 2	il Hygie other ent, th	Be Co	2nd grade 17. Father's Name ( <i>First, Middle, Las</i>	<u>t)</u>	I/A   M	aın	tenance	18. Mother's Name	(First, Middle,	Maiden Suri	name)	Apts
Maryland	2 should be filed was and Mental Hygie Is marked other transmits aumatic event, the	ToB	Charles Edward		19	b. Mailir	ng Address (Street	Esther	Will		wn. State. Ziu	o Code)
	เร 1 and 2 of Health a item 27 Is other trau		Benita Wilson-	-Niece	4	15	Milford	Mill R				MD 21208
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				osition (Name of matory or other place S Mem Pk		-2008	20c. Location	on - City or To	own, State
3alti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	ensee		22	2. Name and Addres	ne of Engility	arch F		ast	
	0 2 2 0 0		23a. Part1. Enter the disease, or co	nolications that caused t	he death. Do	not ent	101 E.	North A	venue	Balto	, MD	21202 Approximate
	Physician /Medical Examiner		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line a. Due to (or as a	NOGA	t	CANCEL		or respiratory air	1631,		Interval Between Onset and Death
A.	dan Fil	iner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consistiumos	ndfr						
68760, ر	rtificate be executed ng physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence	of):						
687	ifficate g phys as the	Medical		d								
P.O. Box	The law requires that the death cer the has been signed by the attendin age 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal deat		Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
	as that gned by se deta	by Ph	Part II. Other significant conditions	contributing to death but	not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ontribute to the	he cause of death?
ord	require een si hould t	ted	propressing a	upranud	con	PC.	sy		1 <b>A</b>	es 2□No	o 3 ☐ Prot	oabiy 4  Unknown
Vital Records,	sician: The law certificate has b irector, page 2 s	Completed					,			sy med? 2 No	prior to co death?	psy findings available mpletion of cause of
Ž	ysiciai s certii directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	Hospital: 1 ☐ Inpatien	2 □ FR/O	utpatien	t 3 DOA Othe	26. Place of Death er: 4 □ Nursing Hor			244 (0	
0 0	ng Phy fter thi	1	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b.	Time of Injury			28d. Describe h			<i>y</i>
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	e 200 Place of injur	y - At home, fi (Specify)	arm, stro	M 1	Yes 2 □ No	28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	al Route Number,
	he Hospita n 24 hours he Funeral pletely filled	Medical C	29a. Certifier (Check only one)  1 Sertifying P 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	examination a	e, death nd/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the deed at the time, d	cause(s) and date and plac	manner as s ce, and due to	tated. the cause(s)
	Vithi Vithi COIII	Ž	29b. Signature and title of certifier	. 1			29c. License		2	29d. Date sig	ned (Month,	Day, Year)
	n		30. Name and address of person who	completed cause of dor	ith (Itam 23a)	/Type !	Print)	7050	> 7	APRICE	16	0008
	'2		AMON S.CH.	plus in	0 61	01	N Cha	5830) Mes St	Tow:	ONA	20	1204
	Sta Registra	~	31. Date filed (Month, Day, Year) APR 1 8 200	2. Registrar	s Signature	bar	le le					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02791 State of Maryland / Department of Health and Mental Hygiene Stephen Douglas Frew Certificate of Death 1- For State Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Year 1622 hrs April 9, 2008 Medical Examiner Stephen Douglas Frew 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford **Bel Air** 520 Mast Street #3 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Country) Days Hours Min Months 219-80-753 Maryland July 14,1962 Director 1 X M 2 F 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Maryland Harford Co Bel Air , or items 23a or 28a-f shorr must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the M-dical Examiner must be notified at once. rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 520 Mast Street 21014 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2 X No Yes Specify: White If Yes, Give Year Yes 2 X No specify: Divorced 3 Widowed þ 6b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 12 N/A Maintenance Harford Mall 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barney D. Frew Nancy LeeBull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3519 Miller Rd., Street, Manyland 21154 Mr. Barney D. Frew (Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 XX remation 3 Removal from State Forest Hill, MD Forest Hill, Maryland 4/11 2008 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services -Belair Legn + COLAN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval een Onset and Physician failure. List only one cause on each line. Multiple Drug (Chlorpheniramine, Hydrocodone and Diazepam) Death /Medical a. Intoxication and Cocaine Use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and 1 be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/21/2008 amh X UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Vunknown و Completed Division of Vital Records, 24a. Was an page 2 should has been prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other: Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Yes 2 X No 1 Natural Pending Fnd 4/9/08 Fnd 4:15p Director: d in by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 520 Mast Street #3 Bel Air MD Suicide (Specify) House determined Homicide

the Hospital or Attending Physician: The law requires that the death certificate be 24b. Were autopsy findings available Certification within 24 hours after death. To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 completely 2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 10, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar ORIĞINAL DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 1:11 A. M Morton Millard Foster Sr. 15, 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Year) July 21, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Ane (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Days Hours 215-07-5512 96 Yrs 1911 Pennsylvania Director Usual Residence of Decedent the Maryland 10h Counts 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Baltimore Maryland Timonium Director 1 ☐ Yes 2 ☑ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country' United States ō of Items 23a 3 Lough Mask Court Unit 202 21093 America Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☑ Married 5 1 ☐ Yes 2 ☑ No Specify. white à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maryland 2121 College (1-4or 5+) Manufacture representative Beauty Aids 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Milton Foster Catherine Elizabeth Adams ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 27 Charlotte M. Foster/ wife 3 Lough Mask Court Unit 202 Timonium, Maryland Department of Heali Important: If Item 2 any Injury or other once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place Garcens, of Faith Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I 18, 14 Burial 2 ☐ Cremation 3 ☐ Removal from State April 4 Donation 5 Other (Specify) 2008 rosedale, Maryland Peacerum Miternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part 1. En er the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PROSTATE CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. End of original Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examil burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \mathbb{X} \) Other (Specify) \( \mathbb{HOSPICE} \) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident

Box 68760 Records, of Vital

2008

FOSTER MORTON Division Hospital or Attending

the Funeral Director: After After the Funeral Director: After the funeral filled in by the funeral fun To the Ivilian 24 To the Ivilian 24 To the Ivilian 24 Complete

State Registrar

cal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date şigned (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be

determined

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** REEMAN 1:05 PM Kudol 2008 /Medical Facility Name (If not institution, give street and numbe 4b. City. Town, or Location of Death BA Himore Examiner 4c. County of Death SALTIMOREVA Medical Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 269602 1 X M 2 □ F 76 Director 01/23/ Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits be notified at Baltimore FSSex 1 □Yes 2 No Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of the filed with and Mental Hygiene. Int: If Item 27 is marked other than "natural", or itel Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 ☐ Divorced Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 501 evinson Thorade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LINK Be Freeman Mari ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) livola You Road Essex MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 Removal from State Garrison Forest 4 Donation 5 DOther (Specify) OwingOMILL, MD 23108 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugher C. Greene Tuneral SVCS aushi Road Candallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sep5/5
Due to (or is a consequence of): disease or condition resulting in death) /Medical Examiner failure un known Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine heart failure Congestive as the burial-train Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Dav Year 4☐Pregnant at time of death signed by the a id be detached for 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has t autopsy performe rmed? 2 🗱 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 🗌 Yes 2 1 Dinpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swor- Yim, 10 North Greene Street BALLIMOREMS 21201 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland /	Department of F		211113	12621
		Mo.	Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )	Certificate of		Reg. No. C O O C	3. Time of Death
	Physici /Medi	al	WALTER 4a. Facility Name (If not institution, give	2 /	FISH	ER ap	th Day Year 16, 2008	3:05PM
1	Examir	er	2611 Garrison	0, 0,0	1 2011	r Location of Death	AC. County of Dea	tn
**	Funeral Director		5. Social Security Number 6. S				of Birth oth, Day, Year) 9. Bir	thplace (State or Foreign ountry)  ARILANN
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location		/ /	10d. Inside City Limits
	hours affer death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral Director	MARYLAND N	IR	B	ALTIMORE		1 X Yes 2 No
	with t	Dir	10e. Street and Number	EN BULL ADET	10f. Zip Code	21216	10g. Citizen of What Co	ountry?
	ter death w items 23a ner must b	nera	26/1 GARRISO 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e	or No- 14. Race - Ame	
9	ours after c ral", or iter Examiner		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes, specify Cuba	an, Mexican, Puerto Hican, e Specify:	tc.) Black, Whit	te, etc.
5-0036	"natural";	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:			1.70	LACK
5	iin 72 n "nat Aedica	Completed	(Specify only highest gra	de completed)	Sa. Decedent's Usual Occup (Give kind of work done) life. DO NOT use retired	during most of working di)	16b. Kind of Business	Industry
2121	d within giene. er than " the Mec	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	JANITOI	R	ST. JOSE	PH HOSPITAL
	be filed tal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last)	(UNKNOWN)		18. Mother's Name (First, I	Middle, Maiden Surname)	
Maryland	2 should be filed w n and Mental Hygie 'is marked other the raumatic event, th	ဥ	19a. Informant's Name/Relationship (7	Timo Drint)	Oh Mailing Address (Chrost	HUDREY	J0	HNSON
Sa (	ges 1 and 2 should be filed within 72 h to f Health and Mental Hygleine. If item 27 is marked other than "natu or other traumatic event, the Medical		FTHEI FISHER	(I) IFF	2/11	150N BLVD.	Number, City or Town, State,	ZIP Code)
re,	of Health of Health fitem 27		20a. Method of Disposition		of Disposition (Name of stery, crematory or other place	Date	20c. Location - City or	Town, State
imo	Page ment c		1 ☐ Burial 2 🛎 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	RO CREMATO	RU 04-21-0	18 BALTIMO	RE MARUIANN
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		21. Signature of Funeral Service Licen	300	22. Name and Address	Bayun Tr. F	FultonAvenue 1	40 21217 Balling
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ilications that caused the death. D	o not enter the mode of dyir	ng, such as cardiac or respira		Approximate Interval Between
	Physician		Im Cause (Final disease or condition	* Acres	Myocaso	SUNC INF	BRCTLOW.	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence		_		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence		22/24	38438X	
	rate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C				
Ő,	be executed ician and burial-transit	Ex	resulting in death) Last	Due to (or as a consequence	e of):			
8760	cate b	dical	•	d				
Box 68	n certifi anding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy		•1.	23d. Date of de	livery V/
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  With the Funeral Director sakib.  Completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown		NIV	Month	Day ( Year
, P.O	that the post of t	y Ph	Part II. Other significant conditions co	entributing to death but not resulting	in the underlying cause give	en in Part I. 23e	. Did tobacco use contribute to	the cause of death?
Records,	equires en sign	q pa	Acore	HEDNAC	DZCONASW	5A7100	1  Yes 2 No 3 P	robably 4 🗌 Unknown
ဝင္ပ	law re as be	plet				24a	. Was an autopsy 24b. Were at	utopsy findings available completion of cause of
E H	cate ha	Con				1	performed? death? Yes 2 No 1 ☐ Yes	. ور
Vit	sician certifi rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	Outpatient 3D DOA Othe	26. Place of Death (Checker:	4	
Division or Vital	g Physer this eral di	<u>ا</u> ا	27. Manner of Death		o. Time of 28c. Injur	4 Inursing Home 57	Residence 6 Other (Spe	ecify)
ion	ath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Worl			
ĬŠ	or Atta	ıţį.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	11/6	28f. Loca City	tion (Street and Number or Re or Town, State)	ural Route Number,
	pital ours a leral C	S	29a. Certifier 1X Certifying Phy	/sician: To the hest of my knowled	ne death occurred at the tir	ne, date and place, and due	to the cause(s) and manner a	c stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certification the Funeral director, tompletely filled in by the funeral director,	Medical Certification:	(Check only 2 Medical Exam	/sician: To the best of my knowled iner: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurred at the	e time, date and place, and du	e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. License	_	29d. Date signed (Mont	th, Day, Year)
	Λ		1/100	I M L	2 0	13619	4.17.0	2
	C'		30. Name and address of person who o	A. 11	(Type, Print)			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Rock .			
	Registr		APR 1 8 2008	flower A.				

DHMH 17 Rev 1/2001

1-

Be Completed by Funeral Director

P

Please	Type or Print in E State of Marylan				-	•	
For State Registrar			rtificate of		Reg	. No. 200	8 12622
1. Decedent's Name (First, Middle, La	ALLS				2. Date of Death Month APRIL	Day Year	3. Time of Death
4a. Facility Name (If not institution, give	,	_		or Location of Dea	ath	4c. County of De	
Baltimore Wash				Burnie   If Under 24 Hr	s. 8, Date of Birth	9 Bi	Arunde1 rthplace (State or Foreign
	1□M 2 <b>X</b> F 82	Yrs.	Months Days	Hours Mir		ear) (	rvland
Usual Residence of Decedent  10a. State 10b. County	10c Cit	v. Town or Lo	ocation			720 110	10d. Inside City Limits
		inthic					1 ☐ Yes 2 No
10e. Street and Number			10f. Zip Code		100	. Citizen of What C	Country?
445 West Maple	Road		21	090		U.S.A.	
11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	erican Indian, ite, etc. nite			
15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usual Occu	pation	orking 16	b. Kind of Busines	
Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire Homemake	*	UINIIY	0	II
12th 17. Father's Name (First, Middle, Last	)		пошешаке	_	ame (First, Middle, Ma		Home
Vac1a	v Rozanek			Mar	y Krepelka	,	
19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street		Rural Route Number, (	City or Town, State,	Zip Code)
Paul Falls / so			Knollwoo	d Road			land 21146
20a. Method of Disposition 1	Removal from State	cemetery, crei	osition (Name of matory or other pla ss Cemete	· 1		altimore,	r Town, State Maryland
21. Signature of Funeral Service Lice	nsee	40 40	2. Name and Addre	ess of Facility Go Le Highwa	once Funera ay Baltim	al Servic ore, Mary	e, P.A. land 21225
23a. art1. Enter the discuse, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the deat one cause on each line.  a. MENING CA  Due to (or as a conseq	TL (		ng, such as cardia		t,	Approximate Interval Between Onset and Death
Sequentially list conditions, in any, leading to infinitionate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a conseq	uenoe of):					
that initiated events resulting in death) Last	c	uence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıl death 3 [	⊒Ectopic pregnand □ Other <i>(specify)</i> _	у		23d. Date of do	I ∋livery Day Year
Part II. Other significant conditions of ENCESHALO Part III		ulting in the u	nderlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Unknown
SRIZURES	,			·	24a. Was an autopsy performe	d2/ I death?	autopsy findings available completion of cause of
25. Was case referred to medical				26. Place of De	1  Yes 2. eath (Check only one)	ŽNo 1 □Ye	s 2□No
examiner? 1 ☐ Yes 2 ☐ Mo  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	" OLI DOX		Home 5 ☐ Residence		ecify)
1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation			M 1 Yes 2 No				
4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif				City or Town,	State)	·
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occ	ce, and due to the cau curred at the time, dat	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier			29c. Licens	se number	290	. Date signed (Mor	nth, Day, Year)

h

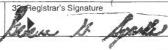
DHMH 17 Rev 1/2001

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Date filed (Month, Day, Year) APR 1 8 2008

710



MD

AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PENNING TON

D51104

2008

21226

MP

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Stamatis Fragoyannis 15, 2008 April 5:07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29, 1929 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2□F 579-58-1895 78 Greece Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Rcckville Director Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 9403 Blackwell Lane, #402 20850 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💢 No White Specify. þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Deli Manager Grocery Store 12 12 should be filed w h and Mental Hygle 7 is marked other tl permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ayero Mustafa Kyriakos Fragoyannis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10505 Rivers Bend Lane, Potomac, Maryland 20854 Dimitrios Fragoyannis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date April 18, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eunioura Physician I wee resulting in death) /Medical Due to (or as a consequence of) Examiner Demeulia duauce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician I for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached for I Yes 2 □ No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🗌 Yes 2 KNO 3 Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 ☐ ¶atural 2 ☐ Accident 5 Pending investigation 1 □ Yes 2 □ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD Sucte atla 2401

State Registrar 31. Date filed (Month, Day, Year)

APR 1 8 2008

DHMH 17 Rev 1/2001

. Registrar's Signature

08-02783 Booker Gelzer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 12624

Discourse per lamine and per lamine			For State		Certificate of Death						Reg. No.								
## BOOKET   Gold Park   Approximation pre-invaled and number   10.6 South Railroad Road   Roa	Physician	/ 1	. Decedent's Name (	First, Middl	e,Last)	st) 2. I								, ,	'ear				
The Testing Name (From tentables, pies where of number)    Futbool   Protection   P					Gelzer						A	April 9, 2	2008				hrs		
The control of the	gr.		a. Facility Name (if r			and nu	mber)		4	•		ocation of I	Death				-	h	
TO GO O'	_	-	Social Security Nu	mher	6 Sex		7. Age (In	vrs. last birth	day)	If Under	1 Year	If Under	24Hrs. 8	B. Date of	Birth (M	M/DD/YY	YY) 9. Bi	rthplace (St	ate or Foreign
The State   Sto County   The Wind   The Wind		- 1				2_F		-			Days	Hours	Min.	7 (	06	69_	Co		ΙΥ
MD Howard Columbia    Columbia		ī	Jsual Residence of D	ecedent														10d Incid	o City Limits
Month   Howard   Ho	any	1	0a. State 10	b. County			10c.	City, Town o	r Locati	on								1	
Section   Control   Cont	<b>*</b>		MD	Н	oward	3		C	colu	umbia	ì							1Ye	s 2 X No
Section   Control   Cont	rylan a-f sl	윉	De. Street and Numi	per						10f. Zip C	ode				10g. 0	Citizen of	What Cou	untry?	
The second control of	or 28	<u>ĕ</u>			B_11	Was	7			2	2104	15				Ţ	J.S.	Α.	
ONCE THE PROPERTY STATE AND THE STATE OF THE STATE O	th the			den				rin II S	13 Wa	1			n? (Speci	ify Yes or	No-	14. Ra	ace - Ame	rican Indian	, Black,
ONCE THE PROPERTY STATE AND THE STATE OF THE STATE O	th wi			1 2 N			orces?		If Y	es, specify	Cuban,	Mexican, I	Puerto Ric	can, etc.)		W	hite, etc.		ļ
ONCE THE PROPERTY STATE AND THE STATE OF THE STATE O	or it	힌			1			No	4	Voc. 2 5	r No	enecify:				Speci	fv: B	lack	
ONCE THE PROPERTY STATE AND THE STATE OF THE STATE O	raffer tiner,				l or Da	tes:		od) 160 F					ind of wor	k done	16		<u> </u>	s/Industry	
Company of the property of the	nours							ed) 16a. L	uring m	ost of worki	ng life. I	DO NOT u	ise retired	d)					
Company of the property of the	1,72 m 1,72	흵		, .	1 '		1~4 01 5+)		Ilna	amala	MAC	٦				τ	Inem	plove	ed l
Company of the property of the	vithii ene.	ĔĹ				11a			Olite				Name (F	irst. Midd	le. Maio			<u> </u>	
Company of the property of the	5-C																		
Colden Bell Way, Columbia, Mc21045   Columbi	121 lbe f ental arke	8 L						106	Mailin	a Address	/Stroot							te. Zip Code	e)
Donation S   Other Species   Providing service Licenses   Providing service   Providing serv	houle m M						ar.												
Donation S   Other Species   Providing	ME 2 S aum;	- 114			er-M	70116													
Donation S   Other Species   Providing	F. Te.				n 3 Re	emoval f		cremato	ory or ot	ther place)		,			-				
236   241   255   256	Page ento	11					ļ	King	Mei	moria	al_I	Park	4/1	16/0	8	Rand	dall	stown	n, Md
236   241   255   256	nit. natusartm	1	21. Signature of Fun	eral Servic	Licensee														
Physician Medical Strill for the complete of t	iii ii De Pa	ı	Blan	da-	w	an	دمه		4	358 <sup>n</sup> v	va 6	ishe.	Äve,	Ва	<u>lti</u>	more	e, M	d 2	
Table Let only one lease of or each of the large of the l	Physician	7	23a. Part I. Enter the	disease	r complication	ns that	caused the	death. Do no	t enter	the mode of	dying,	such as ca	ardiac or r	respiratory	arrest,	, shock, o	r heart		
Due to (or as a consequence of):  Sequentially is condition.  If any, leading to immediate devents resulting in death)  Due to (or as a consequence of):  Due to (or as a conseq		ı,			N.A 14	<sub>ie.</sub> iple G	unshot V	Vounds										1	Death
Top	xaminer	- 1																	
Top		- 1	Sequentially list con	ditions	b													-	
UNPENDED   AMENDED   AME		힐	if any, leading to im	mediate		o (or as	a conseque	ence of):											
UNPENDED   AMENDED   AME		盲	(Disease or injury th	nat initiated	U	- (01.00	0.0000000	onco of):							_			1-	
UNPENDED   AMENDED   AME	lgi gd \	äl	events resulting in o	death) Last		o (or as	a consequ	ence or).											
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	recut		LINIDENIDED	<del></del>		ENDED	`												
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	be ex	췴	UNPENDED													234 Da	te of delix	/en/	
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	76( icate phys	ξ	IF FEMALE: 23b. Was decedent i	pregnant in					. — =	etal death	3	Ectopio	c pregnan	icv					Year
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	68 certif	Ę.			1/2			f .1 1h-											
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	OX eath atte	. <u>S</u>	1 Yes 2 N	10 9 🔲 L	nknown	Unk	nown			Julei (open	,, _								
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	the d	전	Part II. Other signi	ficant cond	litions con	tributing	to death be	ut not resultin	g in the	underlying	cause g	iven in Pa	art I.						
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	P.C.													1	Yes	2 🗸 No	3 F	Probably 4	Unknown
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	S, quires en sig	Ed																	
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	ord w re as be	읦							_										
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	Age 7	E												1	res 2	No	1 🗸	Yes	2 No
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	m: 1			red to medi							26.Place								
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	/its ysicis nis ce direc			2 No	Hospi	ital: 1	Inpatient	2 ER/C	Outpatie	nt 3 D	OA	Otner <sub>4</sub>						ther: Scene	
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	of og Ph	$\vdash$				28a. Da	te of Injury	28b.		f Injury			_ ks	28d. Desc Subject	ribe ho shot	ow injury o	ccurred		
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	Sudin ath.	ţi			ilulig			′   FOI		l	1	Yes 2 🗸	ן מא ן						
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	Afte Afte by the by the	Sa			-	28e. Pl	ace of Injur			reet, factory	, office i	building, e	tc.				Number o	r Rural Rout	e Number, City
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	Div safte	Ē				(Specif	fy) Sing!	e Family					·	104 Sout	h Raiir	road Roa	ad , Heb	ron, MD	
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath Day, Yaar)  32 Registrar's Signature	lospil I hou uner		29a. Certifier	Certifying	Physician:	To the b	pest of my k	nowledge, de	eath occ	curred at the	time, d	ate and pl	ace, and	due to the	cause	(s) and m	anner as	stated.	
29b. Signature and title of certifier  O.C.M.E. April 10, 2008  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Moath, Day, Yaar)  32 Registrar's Signature	the H	Sa	(Check only one) 2	Medical E	xaminer:On	the bas	is of exami	nation and/or	investig	gation, in my	y opinio	n, death o	ccurred a	t the time,	date a	nd place,	and due t	to the cause	(s)
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To with	Med			and	manne	er stated.												
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (North, Day, Year) Registrar's Signature		=	Dist								O.C.	M.E.				April 1	0, 2008	3	
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) Registrar's Signature			COUCL	`				a											
State 31. Date filed (Mogth, Day, Year) 3 Registrar's Signature	H		l						Ponn	Street 1	Raltim	ore MC	21201	l					
SIGHE TO TO TONE ME TO THE TONE OF THE TON						4	t		ı em	oueci, i		J. J. WIL				<del>-</del>			
DOT IN THE STATE OF THE STATE O			31. Date filed (Mor	th Day, Ya	วกกร	14	Registrar's	Signature	ans	154									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** GATEWOOD JOHN April 5 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Belle Vista 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral 215-46-8674 Usual Residence of Decedent 1∭2 M 2□ F Yrs. July 1, 1945 Director Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 →Yes 2 No Baltimore Director mb 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Hvenue 21206 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 ustodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Monroe Doog 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Darlington MD 21034

Date 200. Location - City or Town, State Walter Hess 3741 Dublin 20b. Place of Disposition (Name of cometery, crematory or other place)

Ewans Funeral Chapel 4

Crematory Services - Belfair 4-17-08 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville
8800 Harford Road Parkville mb 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Coronary Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Vear Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Hyperlipidemia 1 Yes 2 No 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 1 8 2008

oreno my

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** HARVEY GUNDERSON 04 12 2008 1813 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 7, 1926 9. Birthplace (State or Foreign Country)

I owa 7. Age (In yrs. last birthday Social Security Number Funeral 1 M 2 □ F 81 482-20-9250 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Cumberland **Allegany** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 703 Montgomery Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 144-47 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) entertainment singer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Wilomena Nicholina Wilson Hans Martin Gunderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kay Shifman/sister in law 701 Montgomery Avenye Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Ronald State Anatomy Board 655 W. Baltimore Street ensee Wade Die 2222 Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aldiogenic Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed as the burial-transit and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō Month in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSI Da 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? 1 ☐ Yes certificate 2□ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 254 No 1 Inpatient 2ER/Outpatient 3 DOA 1 🗌 Yes 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? al or Attending Patter death. Certification: After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier 4/14/99 7818C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Batteet Mahal 952 SETON DRIVE Comberland, LAD 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 8 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** Edward Walter Gurski, Jr. 2008 April 16 10:22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Harbor Hospital Baltimore Date of Birth (Month, Day, Year) 08/12/1961 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 217 78 0637 46 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 10b. County tx Yes 2 □ No Funeral Director N/A Maryland Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be a truy or other traumatic event, the Medical Examiner must be a U.S.A. 524 Arson Avenue 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Self Employee Musical Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward W. Gurski, Sr. Patricia A. Minnick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gurski, Sr. / Brother 321 First Avenue Baltimore, Maryland 21227 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 04/21/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 831 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,  $\prec$ Due to (or as a consequence of): Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2☐ER/Outpatient 3☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1. Natural after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0,

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

but Bolpme Mayland 2125 32. Engistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Physician
/Medical
Examiner

	Dhyeioi	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	n Day Year	3. Time of Death		
	Physici /Medi		Arlene N. Haddock			18, 2008	3:48 AM M		
200	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Death			
			Gilchrist Center for Hospice Care	Towson	•	Baltimor	_		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 h	Irs. 8. Date of Birth		place (State or Foreign		
	Director			Months Days Hours M			intry)		
			Usual Residence of Decedent		-04/09/	1945 NI			
	land ow		10a. State 10b. County 10c. City, Town or Lo	vn or Location 10d. Inside City					
	Mary if sh	Ö	7-11				1 ☐ Yes 2 ☐ No		
	the 28a	Director	MD Baltimore Parkton  10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Cou	ntrv?		
	€ 0 3	盲	Toe. Street and Number	Tot. Zip Gode			,		
	ath \	Funeral	212 Bentley Road	21120		USA			
	r de	<u>#</u>		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White,			
36	afte or i		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify:			
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Evergines must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Wh	ite		
5	72 h	ete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of t DO NOT use retired)	working	16b. Kind of Business/Ir	ndustry		
21	ithin nan '	둳	Elementary/Secondary (0-12)   College (1-4or 5+)						
	d will will will will will will will wil	Ö		emaker		Own Home			
þ	e He He He	Be	17. Father's Name (First, Middle, Last)	18. Mother's I	Name (First, Middle, M	Maiden Surname)			
<u>a</u>	buld be f Mental I arked of atic eve	2	Myron Auerbach	Molli	e Berkowit	z			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc. 18	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or	r Rural Route Number	; City or Town, State, Zi	p Code)		
Ž	5 2 <del>≜</del> 5			Bentley Road Pa	arkton MD	21120			
ō,	<u>a</u> = <u>e</u> =		L	sition (Name of natory or other place)		20c. Location - City or T	own, State		
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of once.		1 Buriai 24 Germation 3 Li Hemovai from State	natory`or other place)	Apr 19				
Ë	tmer tant fury			ake Crematory	2008	Beltsville,	Maryland		
a	permit Depar Impor any in		21. Signature of Funeral Service Licensee M01443	2. Name and Address of Facility					
ш	20 E 20		Inde Sue Willer	Cremation and Fun 8717 Green Pastur			arvland		
л			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between		
2	Physician		Immediate Cause (Final			- 1	Onset and Death		
	/Medical	Ш	disease or condition resulting in death)	1			years		
-	Examiner	Ш	Due to (or as a consequence of):						
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
7	sit ed	Examiner	cause. (Disease or injury						
	rificate be executed ng physician and as the burial-transit	(an	that initiated events c.						
Ó,	ian i		resulting in death) Last Due to (or as a consequence of):						
68760,	ate b nysic	ica	d						
39	death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical	1555.005						
Вох	attending for use a	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	75-1		23d. Date of deliv	very		
_	death e atte	icia	4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
P.0.		Physi	9 Unknown						
	that the dended by the detached		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?		
Records,	sign d be	Completed by	Thranbocypopenia, Liver failur	e due to	1 □ Ye	es 2 No 3 □ Pro	bably 4 Unknown		
0	w requir s been s should	je		4.4	_				
ec	law has b	혈	mutasimore disease		— 24a. Was al autops	v prior to c	opsy findings available ompletion of cause of		
<u> </u>	: The law icate has b ; page 2 st	ĕ			perforr 1 □ Yes	ned? death? 2 XI/No 1 □ Yes	2 □ No		
Vital	t iii	Be C	25. Was case referred to medical	26. Place of	Death (Check only on	+			
>	ysici is ce direc	일	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursin	ng Home 5 □ Reside	ence 6 Dother (Spec	in hospice		
of	Ph eral		27. Manner of Death 28a. Date of Injury 28b. Time o			ow injury occurred			
Division	dlng P th. After funera	Certification:	1 X Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No					
S	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	ica	3 Suicide 6 Could not be 280 Place of Injury . At home form str		28f. Location (St	reet and Number or Ru	ral Boute Number		
<u>≥</u>	or A after Direction by	팋	4 Homicide determined building, etc. (Specify)	•	City or Town		ar ribato rvattibor,		
	urs a					( )	-1-1-1		
	d tho	Medical	29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, deat  2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and p vestigation, in my opinion, death o	occurred at the time, d	ause(s) and manner as ate and place, and due	to the cause(s)		
	To the I within 2 To the I complet	ed	one) and manner stated.						
	7 × it	2	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	, Day, Year)		
			& Glading	V > 830	5 1	HALL 18/	4000		
			30. Name and address of person who completed cause of death (Item-23a) (Type.	Brint)	0-1-1	1117 7 12 1	1=0		
	10		29b. Signature and title of certifier  July  30. Name and address of person who completed cause of death (Item 23a) (Type,  ACAN JULY  31. Date filed (Month, Day, Year)  32/Registrar's Signature	V. Chonces ST	105020N	LIE	7		
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	AP .	72.71				
	Registi		31. Date filed (Month, Day, Year)  APR 1 8 2008	WEL.					
DL			YAK TO COMO PROGRAM						
υHI	MH 17 Rev 1/2	UUI							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEW#4c, perPHYS, 08/8, 4/18/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** YWESTER HAMMER A PR ,264 M Loc 3 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL BAUTMORE MERCY CONTER If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**™**M 2□F 820-24-9424 JULY 16, Director Marylanc Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic ever." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No **Funeral Director** Hartor WD Homador 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify. Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Westinghouse -ngineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Kowalewski Hammer Dylvester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road 938 Creek Park 21014 17.0 MD Michael Hammer-20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapter 4/12/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Haryland 21. Signature of Funeral Service Licensee Evans Fineral Chapet & Cremation Services-Parkuille 8800 Harford Road Parkuille MD 21234 22. Name and Address of Facility dn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infinishing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as ed by the attending detached for use as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Atter this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Onknown 1 Tes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A filled in by the 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier USM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL. BAUTINORE, Registrar's Sign State

Registrar

DHMH 17 Rev 1/2001

Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2008 /Medical 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Wilmont 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1□M 2**X**F Months 3 Director 0.13. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notifled at Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important of Health and Mental Hyglene. Important If item 27 is marked other than "natural", or items 23a or any nlury or other traumatic event, the Medical Examiner must be removed. 21202 ilmont ISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ndary (0-12) College (1-4or 5+) sableo lath 17. Father's Name (First, Middle, Last) Unic 18. Mother's Name (First, Middle, Maiden Surname Be ٥ 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (Type. Print) Rural Route Number, City of Pown, State, Zip Code) Baltimore, mD Jacqueline H. High
20a. Method of Disposition 101 Motker 21202 20b. Place of Disposition (Name of cemetery, crematery or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 1. Nat'l Pilce Baltomore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence ) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, as been signal 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? Yes 2 No certificate Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Déscribe how injury occurred Certification: After Injury 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Macen

Registrar

State

Dol

50

Registrar's Signature

Baltimore

3+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

APR 18

08-02780 Shyanne Harris

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Shyanne Harris Physician/ Month Da April 9, 2008 1200 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Min Hours Months Day Country)MARYLAN Director 2XF Yrs 1 M N/A Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f sho must be notified at once. Director 10g. Otizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Yes 40 Specify: 2 X No specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after to Department of Health and Menlal Hygiene.
Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in Yes If Yes, Give Year 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) A THENA 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Donation 5 Other Specify BROWN 21. Signature of Funeral Service Licenses Approximate Interval Part I. Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death medical Sudden infant death syndrome mmediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED #1,23a,27,perME,G881 7/15/08 TT X UNPENDED led by the attending physician detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be-P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown signed b <u>چ</u> Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been sector, page 2 should prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 2 26.Piace of Death (Check only one) funeral director, 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Other: examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 Yes No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 10, 2008 9-16661 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 31. Date filed (Month Day 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 HACRETT APRIL /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BON SECOURS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Director no 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 Ves 2 No **Funeral Director** m.D 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11:5,A 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Specify. Be Completed by Specify: BACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 15Th GRAGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .2/0/3 eNA 20b. Place of Disposition (Name cemetery, crematory or other Method of Disposition 1 Durial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Sonature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WITH MEFASTASES CAN CER LUNG Physician /Medical Due to (or as a consequence of): Examiner GASTRO IN BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit E Due to (or as a consequence of) physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has 1□ Yes 2 400 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Impatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury 1 Tes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Records, Vital Physician: Division or Hospital or Attending within 24 hours after death.

To the Funeral Director: 4 completely filled in by the fi

Baltimore, Maryland 21215-0036

State Registrar

051 31. Date filed (Month, Day,

8 2008

29b. Signature and title of certifier

29a. Certifier (Check only

30. Name and address of person who completed cause of death (Lism 23a) (Type, Print) A. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0030355

BOX SECOURS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13 **Physician** Walter B. Holladay April 2008 10:52 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Genesis Eldercare Catonsville Commons Cat Baltimore Catonsville Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)
 Texas 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Director 525 09 0358 01/19/1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or a 309 - 14th Avenue 21225 U.S.A. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tunnel Builder Construction 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Benjamin Holladay Cordelia Griffin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothea Holladay / Wife 309 - 14th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 04/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 e, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Shock, or heart failure. I Immediate Cause (Final **Physician** WKY disease or condition resulting in death) /Medical nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1∐ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner state the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 36942 April 14, MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar VRAKNIA

APR 18

31. Date filed (Month, Day,

0 009 32 egistrar's Signature wick Rd. Caturalle, MD 2/228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1 2008 9:00 a M Catherine E . Horne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6520 Walther Avenue Apt B 3 Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 3√X Months 250-42-2467 77 Director 5-3-1930 S.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ā 1 ¥ Yes 2 □ No notifled Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with nand Mental Hygiene 1 is and death of the with "natural", or items 23a or 1 is marked other than "natural", or items 23a or raumatic event, the Madical Examiner must be 6520 Walther Avenue Apt B 3 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Clerical 12th grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othany or other traumatic event 17. Father's Name (First, Middle, Last) Be မ Godfrey Jones Melissa Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Thomas-Daughter 6520 Walther Avenue Apt B 3 Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4-8-2008 Garrison Forest Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East Avenue Balto, 1101 Ε. 21202 North MD used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death

2 Mon hs 23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (un as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit and Due to (or as a consequence of) physician a the burial Box 68760, Physician/Medical the death certificate as ed by the attending I detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) P.O. | 9☐Unknowr 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1**√** Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 1□ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient ဥ 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year)

APR 1 8 2008

SANG

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lee Jones Janet 2008 10:20p<sup>N</sup> 04 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1713 Thomas Ave Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 😾 F Months Days Hours Min. Director 50 215-70-4582 01 57 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Examiner must be notified at Director Y□Yes 2□No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21216 1713 Thomas Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kernan Hospital Material Management llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Fuller ္ရ Arthur Jones Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8317 Mindale Circle Apt C, Balto, Md 21244 Janika Peay-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Baltimore, Md Crematory 4/21/08 21. Sig wur of Funeral Service Lice 22. Name and Address of Facility
March F/H West KompSon 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line.

Immediate if use (Final disease or condition resulting in death)

a. Due to (2000) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a conseque de of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been si page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2**24**0 1 ☐ Yes 2 📉 No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No of Funeral Director; A Funeral Director; A bletely filled in by the fu 2 Accident investigation Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

completely

within 2

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P. . **Physician** MERIL 2008 Jones 23:35PM Mahel India /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death **Examiner** Center Baltimore IOWSOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 □ M 2 🙀 F Director 215-09-2762 90 1918 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Baltimore Dundalk Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8002 Stratman Road 21222 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerical bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hiram Lett Nicholson Bertha Pearl Mansdorfer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Welzenbach (daughter) 8002 Stratman Rd., Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 4-7-08 |Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge spaight speubent P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transi The law requires that the death certificate be execute and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760s attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day 4□Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 Yes 2 No 3 Probably cate has been si, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2[ or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To His To the Hospital Constitution of the Within 24 hours after death. To the Funeral Director: After this considered if the funeral constitution is the funeral constitution. 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my calcium, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) APR 18 2008

KHOSŔOW

29b. Signature and title of pertifier



30. Name and andress of person who completed eause of death (Item 23a) (Type, Print)

29c. License number

D46356

29d. Date signed (Month, Day, Year)

MARYLAND 21204

08-02869 George Jones		Please Type or Print in Black Indelible Ink. Ensure All Copies  State of Maryland / Department of Health and Mental Hye  For State  Certificate of Death	s <b>Are Legib</b> giene		18 1263
	R		2. Date of Death		3. Time of Death
Physician Medical Examin	.,	George W. Jones, JR.	April 12, 2008		1328 hrs
\$	4	la. Facility Name of not institution, give street and number)  4b. City, Town, or Location of Death  Patimore		4c. County of Death	
		2417 Madison Avenue Baittimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		M/DD/YYYY) 9. Birth	place (State or
Funeral Director	6	218-22-9695 1XM 2 F 83 Yrs. Months Days Hours Min.	12/15/1	924 Foreign Cour	ntry) MD
w any	_	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Baltimore			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number 10f. Zip Code	10g. (	Citizen of What Coun	try?
th the l		2417 Madison Avenue 21217  11 Martal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Americ	can Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Mantal Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married Forces? 1 Yes 2 No 1 Yes, Give Year 1 Yes 2 No specify:	Rican, etc.)	White, etc.  Specify: B	ack
hours afte	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the prope	vork done 16 red)	Baltimo	re City
5-0036 led within 72 h Hygiene. I other than "1, the Medical k	mplet	Elementary/Secondary (0-12)  College (1-4 or 5+)  Teacher	(First, Middle Maid	Public ?	Schools
215-0 e filed with all Hygie sed other	Be Col	Dora Dora	- John	son	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	ToE	19a. Informat's Name/Relationship (Type, Print) (Cousin) 19b. Mailing Address (Street and Number of Rev. Brenda McBride (Cousin) 2414 Frederick AV		7 - 5	2/223
e, MD 1 and 2 sho Health and Health and item 27 is	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	Oc. Location - City or	
Baltimore, permit. Pages I a Department of He Important: If ite		E Constant C	25.08	Juings 1	Wills, and
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funital Service Licens le	11/1/c	(2124	)
Physician		23a. Part I. Ence the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
Medical aminer	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			1
		Sequentially list conditions.			1
	xaminer	if any, leading to immediate Due to (or as a consequence of):			
/ D, a _ isi	Exan	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760, ficate be executed ficate be executed g physician and ithe burial - transi	an/Medical Ex	UNPENDED AMENDED			
760, cate be physici	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregram	nancv	23d. Date of delive Month	ry Day <b>Y</b> ear
Box 68760 e death certificate be the attending physice of for use as the bu	cian	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		l.	
Boy ne death the att	Physici	Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
s, P.O. ires that the signed by 1	百		1 Yes		obably 4 V Unknown
cords, law require has been sig	Completed		24a. Was ai autops	y prior to	autopsy findings available o completion of cause of
ecol he law ite has	dmo		perform 1 Yes 2		Yes 2 No
Vital Rec ysician: The l his certificate l director, page	BeC	25. Was case referred to medical		Residence 6 🗸 Oth	ner: Scene
f Vit Physici er this o	l٥	1 V Yes 2 No limpaterit 2 Erosapean 28c. Injury at Work?		ow injury occurred	
on o nding ath. r: Afte	E E	1 Natural 5 Pending (Month, Day,Year) 1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requirant and anger death.  All Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	28f. Location (S or Town, St		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	al Cer		nd due to the cause	e(s) and manner as stand place, and due to	tated. the cause(s)
To the within Comple	Medical	and mariner stated.		29d. Date signed (f	
	2	29b. Signature and title of certifier  O.C.M.E.		April 13, 2008	
0		30. Name and address of person who completed cause of death (Item 23a)	MD 04004		
18		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	IVID 21201	<del></del>	
Pogi	State	MEN IN THOU AND MAKE A MENTAL MAKEN			

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician APRIL 6:28 PM 2008 EANETTE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs\_last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F 644 Director AND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MARYLAND 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Ilmportant: if item 27 is marked other than any injury or other traumant. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 □ Removal from State 4 Domation 5 ☐ Other (Specify) 21-08 BALTIMORE 22. Name and Address of Hapity BROWN 3 BROWN JR. FUNERAL HOME 21. Sgnature of Funeral Service Lioensee careline BALTO MD part. Enter the lisease, or complications that caused the death. shick, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm diate Cause (Final dix ase or condition resulting in death) SUB-ARACHNOID **Physician** HEMMORAGE Week /Medical Due to (or as a consequence of) Examiner YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) physician Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Dav 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 3 Probably 4 □Unknown 1 Yes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No After this certificate has page 2 autopsy Division or Vital 10 25. Was case referred to medical funeral director, Be 26. Place of Death Check onl one) examiner? 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

State Registrar

DHMH 17 Rev 1/2001

KSON

AC

DEAL S

AJAT

Registrar's Signature

CATON AVE

MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 17:06 MOZUHOC 11th 2003 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 20HNS HOPKINS BALTIMORE VA HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) MAY24, 19. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗙 F 220-186902 Usual Residence of Decedent **Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2□No Director BAITIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4or 5+) Elementary/Secondary (0-12) nestic 扶 GRAGE and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: if item 27 is
any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Parrune annois and 21313 BALTE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SCHEMIC DAYS /Medical Due to (or as a consequence of): Examiner CYAS BOWEL PERFORATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit CARDIAC ARCHYCHIMIA DAYS Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9□Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? res 22 No certificate 1 ☐ Yes 2□No 1□ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES - 000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

Registrar

State

JASON Y K CHAN

31. Date filed (Month, Day, Year) APR 1 8 2008

STREET

NORTH WOLFE

600

32. Registrar's Signature

BALTIMORE

MO 21287

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Department of Health and Mental I Certificate of Death	Hygiene 0 0 8   264   Reg. No.
Physici /Medi	cal .	1. Decedent's Name (First, Middle, Last)  JACKSON	2. Date o	Day 2008 17:30 P M
Examir Funeral	ier	4a. Facility Name (If not institution, give street and number)  POD SECOM AS HOS PIT N  5. Social Security Number  6. Sex  7. Age (In yrs. last birth  0.83 -66 -69 22  1 № M 2□ F  39		4c. County of Death    333
Director woys	č	U83-66-6922         Jusual Residence of Decedent           10a. State         10b. County         10c. City, Town		10d. Inside City Limits ty⊡Yes 2 □ No
with the N a or 28a-f Le politi	Funeral Director	10e. Street and Number 1217 W. Fayette Street	10f. Zip Code 21223	10g. Citizen of What Country?  USA
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-1 show ant, the Medical Extentine coattle and the all	by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give  1 Widowed 4 Divorced Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian,
21215-0036 ad within 72 hours aff giene. er than "natural; or t, ir a Medical Extern	npieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  unk  16a.  College (1-4or 5+)  unk	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	nk 16b. Kind of Business/Industry unk
land Z uid be filed Aental Hygie rked other tic evant, II	To Be Co	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Mi	iddle, Maiden Surname) unk
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, the Modical Executors to notified at any injury or other traumetic event, the Modical Executors to notified at agree.		Bon Secours Hospital 20  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify) in state	. Mailing Address (Street and Number or Rural Route N 100 W. Baltimore Street Ba f Disposition (Name of y, crematory or other place)	
Departiment in the control of the co		21. Ignalum of Funeral Sarvie: Licensee Ronald S. Wade, 12 23a. Part I. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility State Anatomy Board 655 Baltimore, MD 21201 not enter the mode of dying, such as cardiac or respirate	
8760, cate be executed XI by by by sician and burial-transit about a	icai Examiner	Immediate Cause (Final disease or c ition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of the	L PNEWMONIA 5 AIDS	Onset and Death
ecords, P.O. Box 68/60, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	a 3 ⊟Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
cords, P w requires that been signed b should be deta	þ	OZEC I MAIA MTE D DA A I	in the underlying earlies given in race.	Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 X Unknown
The ate h	Completed	SACRAL DECUBITUS ULCER		Was an autopsy perior inclined? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Division of Vital Records,  To the Hospital or Attending Physician: The law requires t within 24 hours after death.  To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: Inpatient 2 ER/Ou		only one)  Residence 6 □Other (Specify)  cribe how injury occurred
Division tel or Attending s after death. al Director: Afte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office 28f. Local City of	tion (Street and Number or Rural Route Number, or Town, State)
Fo the Hospi within 24 hour To the Funer completely fill	Medical	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place, and due to advertised in the death occurred at the 29c. License number	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
F > F 0		Jorda V - Walk blu , M  30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) D14949 W - BRITI	4/11/2008 invente STREET
Si Regis	ate trar	JANT V. MWTHMEN, MD  31. Date filed (Month, Day, Year)  APR 1 8 2008	gode on mone, me	71883

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3:48 P M Johnson 2008 Louis Martin April 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore 8217 North Boundary Road Dundalk If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Director Yrs. 1, June 1961 Maryland 216**-**80**-**5339 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f sho the Midical Exp. Inc. o ust by notfilled at 1 ☐ Yes 2 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 8041 Grav Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2Yes 2 No 1979- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify à Specify: White 1982 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the W Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall 12 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Margaret Roupe Norman Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i 8041 Gray Haven Road Dundalk MD 21222 <u>Jacquline Johns</u>on ( Wife ) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. ō 4 Donation 5 Dother (Specify) 04-18-2008 Middle River MD Holly Hill Mem. Gdns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk MD 21222 Ci 1. Enter the disease, or completions that caused the shock, or heart failure. List only one cause on each line, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami P.O. Box 68760, Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 T Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? Division of Vital Records, þ be 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 10 No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Mother's Certification: To 1∐ Yes 2∭ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation s after death. 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 24 hours a 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

6+1

State Registrar SUMAN

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

UARLE

RIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

AC

8 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** EUGENIA OTRICE JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Ba Baltimore H05 HMOVE 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖫 F Director FEB. 5, 1934 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County items 23a or 28a-f shov ner must be notified at Director MD BALTIMORE Baltimore, Maryland 27215-0036 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2014 MCKEAN AVE. 21217 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No 'natural", or Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2X No 2 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH DOMESTIC PRIVATE and Mental Hygid per it. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumant event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WILLIAM BOOKER GEORGIA B. WILSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE JOHNSON, JR. 2400 LINDEN AVE., BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location City of Town State 5712 O DONNELL ST. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. CARMEL 04/17/2008 BALTIMORE, MD 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h each line. Immediate Cause (Final DISEASE ALZHEIMENS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, fany cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 0 in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 □ Physician: 25. Was case referred to medical examiner? 1 151 Yes 2 □ No Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Monner of Death funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64869

(OUT(MI) M-1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PACA

LT I MORE,

. Registrar's Signature

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

21231

Approximate Interval Between Onset and Death

7 YEARS

Day

2 No

2008

Year

1XYes 2 □ No

138 AM

Year

2008

State Registrar SOUTH

MP

Division or Vital Records, P.O. Box 68760, the within 7

Medical 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D20108 MONO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4300GALLANTFOXLN#222 BOWIE MD20715 31. Date filed (Month, Day, Year) APR 1 8 State 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 15, Rollin Todd Kingsley April 5:09 P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign Country) Minnesota If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1323M 2□ F 468-60-4422 59 July 15, 1948 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Predical Examiner must be notified at 1 ☐ Yes 2 No Towson Maryland Baltimore Director 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21204 1601 Twin Maple Avenue America Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 72 hours after 1√T¥es 2 ☐ No IfYes, Give Year or Dates: 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene, 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Special Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Magnaheld Peterson Lee Malcolm Kingsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1601 Twin Maple Avenue Towson, Maryland 21204 Department of Health ar Important: If item 27 is any Injury or other trau Pages 1 and 2 Pamela Pearce Kingsley/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20c. Location - City or Town, State Date 20a. Method of Disposition April 17, 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Forest Hill, Maryland 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes ? □ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nu Spice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 12 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

Check only one) 29a. Certifier 29d. Date signed (Month, Day, Year) 29c License number 58303 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARW J CHARLES WY 6701 N-Charles ST POWSOW MO 21204 1241

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 18

5,09 pm

Kingsley, Rollin

32. egistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State of Marylan    = State Registrar		rtificate of Dea			. No. 2 0 0 8	12641	
Physicia		1. Decedent's Name (First, Middle, Last)	-		2	Date of Death Month	Day Year	3. Time of Death  X 11:55PN	
/Medica	Acres .	Arthur R. Koehrer  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death	1011	4c. County of Dea	0	
Examilie	51	Washington County Hospital		Hagerstown			Washingt		
Funeral Director		5. Social Security Number 6. Sex 1 M 2 日 F 6. Sex	last birthday) Yrs.		Jnder 24 Hrs. Sours Min. M	B. Date of Birth (Month, Day, Y ay 6, 19	942 Mar	rthplace (State or Foreig ountry) yland	
Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		Usual Residence of Decedent           10a. State         10b. County         10c. Cit	y, Town or Lo	ocation				10d. Inside City Limit	
-f sho	ţ	MD Washington	Hager	stown			1 ☐ Yes 2√7 No		
or 28a e noti	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	country?	
s 23a nust b	ral	720 Chestnut Street Rear  11 Marital Status   12 Was Decedent Ever in U	C 13		740	ifv Yes or No-	USA 14. Race - Am	erican Indian,	
	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  13 □ Yes 2 □ No If Yes, Give Year or Dates:  160—		Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 🌠 No Sp	lexican, Puerto R pecify:	ican, etc.)	Black, Wh	<sub>ite, etc.</sub> white	
"natural ledical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)	16a Dece	edent's Usual Occupation e kind of work done during DO NOT use retired)	ı g most of workin		6b. Kind of Busines	s/Industry	
and Mental Hyglene. is marked other than aumatic event, the M	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 0	mach	nine operato			atio bri	cks	
d other	Be C	17. Father's Name (First, Middle, Last)			Mother's Name Edna Mar		aiden Surname)		
narkec natic e	2	Arthur Jacob Koehrer	10b Maili	ing Address (Street and N			City or Town, State	. Zip Code)	
7 is metraum		19a. Informant's Name/Relationship (Type. Print) Judy Koehrer/spouse		Chestnut St					
Important: If item 27 i any Injury or other tra		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disp cemetery, cre	osition (Name of ematory or other place)	Da	ate 20	0c. Location - City of	or Town, State	
Important any Injury once.		4\(\text{\text{Donation}}\) 5 \(\text{Other}\) (\$\(\text{Specify}\) 21. Signature of the ral Service Licensee \(\text{Onald}\) S. Wade, \(\text{Differential}\) 12.		22. Name and Address of tate Anatom		655 W.	Baltimore	Street	
		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not er	altimore, M nter the mode of dying, su			st,	Approximate Interval Between Onset and Death	
attending physician and for use as the burial-transit	al Examiner	Sequentially list conduints, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conservation of the conservation of	quence of): quence of):	ATORY FR	THY				
as the	Aedical	u							
the attendir ned for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	☐Ectopicpregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year	
been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not re					acco use contribute s 2 □ No 3 □	e to the cause of death Probably 4 Junkn	
has le 2	Completed	ATRIAL FIBRILLATIO				24a. Was an autopsy perform	y prior ned? death	autopsy findings avai to completion of cause i? 'es 2 \sum No	
certificate ector, pag	Be C	25. Was case referred to medical examiner?			6. Place of Death	(Check only one	)		
After this couneral dire	은	1 ☐ Yes 2 ☐ No Prospital: 1 ☐ Inpatient 2 ☐  27. Manner of Death 1 ☐ Natural 5 ☐ Pending  1 ☐ Natural 5 ☐ Pending	28b. Time Injury	of 28c. Injury at Work?			nce 6 Other (S w injury occurred	pecify)	
within 24 houls aider death.  To the Funeral Director: After this certified completely filled in by the funeral director. I	Certification:	2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined 28e. Place of injury - At building, etc. (Spec	home, farm, s cify)			28f. Location (Str City or Town	reet and Number of , State)	Rural Route Number,	
24 hours e Funeral letely filled	Medical Co	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my king the basis of examination and manner stated.	nowledge, de nation and/or	eath occurred at the time, investigation, in my opini	date and place, ion, death occurr	and due to the ca red at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)	
within To the	Me	29b. Signature and title of certifier		29c. License nu			9d. Date signed (M		
		Myal			06200	6	4-14	-08	
		30. Name and address of person who completed cause of death (Ite		e, Print)	4	A A*	- 411/	50 (Tille )	
		31. Date filed (Month, Day, Year) 32 Registrar's Sig	2S1	EAST A	NHEN	+m 51	. 170+9	ERSTON U	
Sta Regist	ate	APR 1 8 2008	K A	naile					

DHMH 17 Rev 1/2001

APR 14 PHB:27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 5, perFH, C8/8, 4/18/08, W.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

1- State amend item 5 per fh g879 5-2-08 Finicate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14 Day 2008 **Physician** Harry Ludwin 7:49 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14508 Homecrest Road Silver Spring Montgomery 5. Social Securi 9569 9560 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/29/1914 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 147-18-7560 1 M 2 □ F 93 Director NJ Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD Montgomery Silver Spring Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 Homecrest Road 20906 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Butcher 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Ludwin Esther Ruder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elliott Ludwin / Son 5 Diamond Drive, Edison, NJ 08820 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Moriah Cemetery 04/17/2008 Fairview, NJ 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cite myo cardiel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 1 □ Yes 2 □ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 20 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D &x 6 \$129 MO 2008 M.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Sik 730 Chevy Chox, MO 20815 30 Wisconsin are, Colc. M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

APR 1 8 2008

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 1125 A M 2008 Mae ohnn Horil 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hyattsville More George Nursing Home Ihomas If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Days 579-30-2645 Months 1 ☐ M 2 🔀 F January 7, 1919 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Arlinaton 1 ☐ Yes 2 No Arlington Virginia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 A +illmore South 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Slack 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1erK S. Governmen 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Black mon Koebuck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hunters Run Blvd. Cohoes Henry Leak NewYork 12041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 23/08 Annandale, Virginia Pleasant Valley Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee obert China Funeral Service 2605 S. Shirlington and Arlington, Va. 22206 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final In ten eschenote Candwovarcolan Distris ears disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day signed by the aid be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal 17 1 Yes 2 No istate 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No e muentia 24a. Was an autopsy performed ram positive SEPSIS 25. Was case referred to medical examiner? To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P elfer death.

I prector: After this din by the funeral di After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗌 Yes 2 🗀 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J 31. Date filed (Month, Day, Year) trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Juseph Baltimore, Maryland 21215-0036 ehnbeuter

Please T	ype or Print in Black Indelible Ink. Ensure A	_
For State	State of Maryland / Department of Health and N	2000 10610
State Registrar	Certificate of Death	Reg. No. 2 U U U 1 2 D 4 3
1. Decedent's Name (First, Middle, Last)	Sahastian lehahanler	2. Date of Death Month Day Year 3. Time of Death Worth October 1.5 2008 0258 A.M.
4a. Facility Name (If not institution, give	street and number)  4b. City, Town, or Location of Death	
FRANKLIN SQUARE	- Hospital Center Rosedale	Baltimore
19 1-00-1170	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth   9. Birthplace (State or Foreign Country)   1. Curl   1. C
Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
mo Bait	more Parkville	1 □Yes 2 ☑No
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8648 Oak K	00d 21234	U>H
11. Wallar States	12. Was Decedent Ever in U.S. Armed Forces? I3. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?)	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: NON Y 1 Yes 2 No Specify:	specify: White
15. Decedent's Edu	cation 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
(Specify only highest grad		McDonnell.
Elementary/Secondary (0-12)	NIA Draftsman	Aircraft
17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Surname)
Joseph	-ehnbeuter   An	na Marti
19a. Informant's Name Relationship (Ty	pe. Print) (50) 19b. Mailing Address (Street and Number or Ru	ural Route Number City or Town, State, Zip Code)
Kenneth E. Le	ehnbeuter 13003 tarktown	e Kd. tarkville mp alaby
20a. Method of Disposition  1	lemoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	9-08 Parkville, MD
21. Signature of Funeral Service Cleens	Services & 800 Hay	ans Funeral Chapel of Cremation
23a. Part . Enter the disease, or compl shock, or heart failure. List only o	cations that caused the death. Do not enter the mode of dying, such as cardiac recause on each fide.	c or respiratory arrest, Approximate Interval Between Onset and Death
Immediate Cause (Final / disease or condition	preumonia	Onset and Death
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate country in Cause (Disease or injury	Due to (or as a consequence of):	
that initiated events resulting in death) Last	Due to (or as a consequence of):	
	4	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Dea	ath (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Vork?  Injury  M 28c. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	sician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occ	

**Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

State Registrar

H NGUY DR Binh 31. Date filed (Month, Day, Year)

Completed by Funeral Director

Be 2

Examine

Physician/Medical

þ

Medical Certification: To Be Completed

(Check only one)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

and manner stated. 29b. Signature and title of contifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed of use of death (Item 23a) (Type, Print)

19000

FRANKLIN Square DR Balto md 21237

32. Negistrar's Signatur 2008 APR 18

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1210 PM 2008 Linda Lucas 72/4 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Isalt, more N/A USp. tos MARBIA Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 56 220 90 7762 08/12/1951 Marvland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 X Yes 2 No Director N/A Baltimore Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or ? with 3744 - 10th Street U.S.A. 21225 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 TNever Married 2 Married Specify: White 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/ADisabled 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Mary Phelps Joseph Lucas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Health a Cheryl Miller / sister 3744 - 10th Street permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/11/2008 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) immediate **Physician** CAIZd AC ARR /Medical Due to (or as a consequence of): Examiner MTOCARdia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and HTPERTENS, U, Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical DIABETES 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined To the Hospital within 24 hours at To the Funeral E 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061438 mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bothmore MD ANDREW S. HAnover St 31. Date filed (Month, Day, Year) State APR 1 8 2008 Registrar

15,

APRIL

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voor **Physician** Ruby G. Young - Lee 4:08 4 15 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Stella Maris Hospice Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F Director 11-19-1950 213-50-3577 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglein-te. Important: If Health and Mental Hyglein-te. Important: If Hear Z1 a marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Predict Exercite must be multiled as MD N/A 1 XYes 2 No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 TT S Funeral 2428 Ashland Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Health Department Office Assistant 12th grade 17. Father's Name (First, Middle, Last) years 18. Mother's Name (First, Middle, Maiden Surname) Be Hastey Young Millise White ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22901 V.A 19a. Informant's Name/Relationship (Type. Print) Charlottesville Gwendolyn R. Lee-Daughter 520 Georgetown Road Apt C 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4-19-2008 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Pk 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E. North Avenue Baltimore, MD21202 ans 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RECTAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 24 hours after death. Puneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 2 one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) APR 1 8 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #16b Per FH G878 4/18/08 Is a Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bernano Month 2554M **Physician** 2008 t pri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth
Month, Day Year)
12/03/1923 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days IL 218-14-5897 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. The state 12 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ite Marklical Expansion mant Lec nutlind at uny or other traumatic event, Ite Marklical Expansion mant Lec nutlind at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2710 SUMMERSON ROAD 21209 Funeral 12. Was Decedent Ever in U.S.
Artiped Forces?

1 Mayes 2 □ No ATR
If Yes, Give
Year or Dates: FORCE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR PROPRIETOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNOBTAINABLE LIPMAN DOROTHY SAMUEL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2710 SUMMERSON ROAD, BALTIMORE, MD 21209 ELAINE LIPMAN / WIFE 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page Department o Important: If any Injury or once. BETH EL MEMORIAL PARK 04/17/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 nions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each lige. 23a. Part . Enter the disease, or complication of heart failure. List only one Immedi \*\* Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 🗆 No 1 ☐ Yes 2 🗖 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

T: 4 \( \text{Nursing Home} \) 1 Residence Be Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar

100000 31. Date filed (Month, Day, Year) APR 1 8 2008

29b. Signature and title of certifier

Registrar's Signature

29d. Date signed (Month, Day, Year)

29c. License number

completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 946 AM Patrick G. McCurley 2008 16 APRIL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death n/a SAINT BALTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 7/5/1952 1 X M 2 □ F 212-58-3972 Maryland 55 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TylYes 2 □ No Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 2423 Christian Street 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Steel Worker Mfq. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Milton McCurley Rita Virginia Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2423 Christian Street, Baltimore, MD 21223 Anita McCurley / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/18/2008 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign ture Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY 1 WEEK FAILURE Due to (or as a consequence of): LUNG CANCER Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 in July or other traumatic event, the Midical Examiner must be repore.

Baltimore, Maryland 21215-0036

Examiner must be notified

Director

Funeral

þ

Completed

MD

certificate After this death. after death filled in by the

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the Hospital within 24 hours a To the Funeral C

MCCURLEY

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown þ Completed 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an

death? 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

1 Yes 2 No 3 Probably 4 Vinknown

autopsy

perform

BALTIMORE

24b. Were autopsy findings available prior to completion of cause of death?

P 20809

APRIL 16 2008

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 18 2008



DHMH 17 Rev 1/2001

5

State

Registrar

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 12654

			1- For State Registrar	Certificate o				g. No.	00 1200
יי יע	Physic cal Exam	ian/	Decedent's Name (First, Middle,Last)				2. Date of Death	h Day Year	3. Time of Death 1212 hrs
			4a. Facility Name (if not institution, give street and number) John Hopkins Bayview Medical Center		4b. City, Town, o Baltimore	r Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 X M 2 F	e (In yrs. last birthday) 61 Yr	If Under 1 Ye Months Da		8. Date of Birt		Birthplace (State or Foreign Country) VA
	Maryland 28a-f show any d at once,	or	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Loca Baltimo:					10d. Inside City Limits 1 X Yes 2 No
	with the Maryland us 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 302 Hudson Street		10f. Zip Code 21224		10	og. Citizen of What C United S	· ·
	fter death ", or iter er must	/ Funeral	11. Marital Status  1 Never Married 2 Married 2 Armed Forces?  1 Yes 2  3 Widowed 4 Divorced If Yes, Give Year Vice	No If	as Decedent of H Yes, specify Cuba	ispanic Ongin? (Span, Mexican, Puerto o specify:	ecify Yes or No- Rican, etc.)	White, et	merican Indian, Black, c. merican India
ç	24 3 🗆	Completed by	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)  College (1-4 or 12)	npleted) 16a. Decede	ent's Usual Occup	ation (Give kind of ve. DO NOT use reti		16b. Kind of Busine	
7	Z1Z15-UU36 vuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Lewis Mullins			18.Mother's Name Artha Mu	•		
2	MC sho alth and m 27 is aumati	To	19a. Informant's Name/Relationship (Type, Print) Ruth Kavalesky, Sister	302 I	Hudson S	treet, Ba	ltimore	ber, City or Town, S , MD 2122	4
	Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition  1 Bunial 2 Cremation 3 Removal from St.  4 Donation 5 Other Specify:  21. Signature of Puneral Service Licensee	Silyders	ther place) Cremator	y 04/2	Date 2/2008	20c. Location - Cit	
			21. Signature of Funeral Service Licensee  23. Part I. Enter the rise se, or complications that caused	1		erside Dr	rive, Po	neral Hom und, VA 2	4279
	Physician 'Medical ≟xaminer		failure. Lilfonly one cause on each line.	Cardiovascular Dis		g, such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
		Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a const						
14	cecuted and - transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	equence of):					-
9	a a e	Medical	UNPENDED AMENDED	no of progress				23d. Date of del	
700	OX 68 ath certif attending or use as	Physician/N	23b. Was decedent pregnant in the past 12 months?	2 Fe	etal death 3 Other (Specify)	Ectopic pregna	incy	Month	Day Year
	he t	<u>م</u>	Part II. Other significant conditions contributing to death Chronic Obstructive Pulmonary Disease	but not resulting in the	underlying cause	given in Part I.			e to the cause of death?  Probably 4 Unknown
7	The law requested has been page 2 should	Completed					24a. Was a autops perform	sy prio	e autopsy findings available to completion of cause of th? Yes 2 No
145	VITAI KE hysician: The this certificate I director, page	o Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗸 ER/Outpatien		Other Nursin		Residence 6 0	Other:
90	ION OT VITAL I tending Physician: leath. tor: After this certifi the funeral director,		27. Manner of Death  1  Natural 5 Pending 2 Accident Investigation	(ry 28b. Time of		ury at Work? Yes 2 No	28d. Describe h	now injury occurred	
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined (Specify)	jury - At home, farm, stre	eet, factory, office	building, etc.	28f. Location (S or Town, St		r Rural Route Number, City
_	To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edical	29a. Certifier 1 Certifying Physician: To the best of m one) 2 Medical Examiner: On the basis of examiner and manner stated.						
		Me	29b. Signature and title of certifier			se number .M.E.		29d. Date signed April 16, 2008	(Month, Day, Year)
	17/10		30. Name and address of person who completed cause of d Ana Rubio MD. Assistant Medical Exam		Street, Baltim	ore, MD 21201	l		
	S Regis		31. Date filed (Month, Day, Year) 2. Registra	r's Signature	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2230 PM 4a. Facility Name (If not institution, give street and number) 12 April 8006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

12/30/1952 Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Months 1 □ M 2 🖾 F 212 60 5753 55 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 Norfolk Road U.S.A. 21061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Murphy, Larel Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Account Tech. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Oswald Ruth Pivonski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Norfolk Road Glen Burnie, Maryland 21061 Michael Murphy / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) important: If it any injury or o Cedar Hill Cemetery 04/16/2008 | Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signa up of Fur eral Service Licensee Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or rijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ası attending p for use as IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 🗖 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ AZTHZITIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No RITEUMATOID has autopsy performed page After this certificate 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

A.

31. Date filed (Month, Day, Year)

VITBERF

APR 1 8 2008

BURNE.

301

HOSPITAL

32. Regimar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEW/14, per HYS. C8/8,4/30/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** рМ 1643 April 2008 Newkirk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, ) Jan. 13, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1941 North Carolina Social Security Number 7. Age (In yrs. last birthday) 1 MM 2□ F Jan. 243-60-2590 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 X Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20904 13900 Castle Blvd. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Almed Folces: 1 MYes 2 No If Yes, Give Year or Date∜ietnam 1 Never Married 2 Married Black 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Corrections Officer Prisons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Newkirk Arthalia Lee ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Newkirk 553 Manley Ave., Wilmington, NC 28401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Calvary Memorial 4/19/08 Wilmington, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John H. Shaw's Sons Funeral Home 21. Signature of Funeral Service Ligense 520 Redcross St., Wilmington, NC 28401 Jennes Villmen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Cardiac Arrest Due to (or as a consequence of): Diabetic Ketoacidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Seizure Disorder Due to (or as a consequence of) Physician/Medical Acute Renal Failure IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed burial-t Division or Vital Records, P.O. Box 68760, attending physician for use as the buria s certificate has b irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p.

**Funeral** 

Director

28a-f sh notified

De d

ral", or items 23a Examiner must b

event, the Medical

Important: If it any Injury or o

**Physician** 

/Medical

Examiner

death v

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iten

Saltimore, Maryland 21215-0036

Majid Rohmanion, M.D. 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

R. Amarica, Morjet

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd., Silver Spring, MD 20910

APR 1 8 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:00 am Alice Arlene Norfolk April 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Summitt Care Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 216-20-3124 Baltimore, MD Director 60 09/02/1947 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 556 Lucia Avenue 21229 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d other than Elementary/Secondary (0-12) College (1-4or 5+) Professional/Legal Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William S. Norfolk Emma Virginia Rohrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 556 Lucia Avenue, Baltimore, Maryland 21229 Emma Virginia Danner (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 04/18/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier Rd. Coforgisle, no 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MD KNIA 1009, Frederick gistrar's Signature 31. Date filed (Month Year) State 8 2008 Registrar

#### Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frank William Osgood Jr. APRIL 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 45 1 ★M 2 🗆 F 483-82-8774 Director August 23,1962 Washington D.C Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Baltimore Maryland Timonium Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States than "natural", or Items 23a or the Medical Examiner must be 3 Baratra Court #104 21093 America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Narried 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Art Litho 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank W. Osgood Ann Ellin ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann Pinter/ mother 1009 W. Seminary Avenue Timonium, Maryland 21093 20b. Place of Disposition (Name of semiclary crematory of other place) Chapel - Bel Air 20a. Method of Disposition 20c. Location - City or Town, State April 16, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition intracranial hemmorhage **Physician** /Medical Examiner sician and burial-transit the

Division or Vital Records, P.O. Box 68760. s been signed to should be det page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

	disease or condition resulting in death)	a Intracri	anial h	emuorha	ge		3 d	ays
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consecuence of the boundary		e muoiha Multifor	me		2 ye	ays cars
dical Exa	resulting in death) Last	Due to (or as a consec	quence of):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	al death 3□Ectopi	c pregnancy (specify)		23d. Date of de Month	livery Day	Year
Ϋ́	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause o	of death?
led k					1 ☐ Yes	2 <b>⊠</b> No 3□P	robably 4 [	∐Unknown
Complei					24a. Was an autopsy performed 1∐ Yes 2 🔀	?   death?	utopsy finding completion o	gs available f cause of
Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)			
2	1 ☐ Yes 2 No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)	
	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route N	umber,
Medical	29a. Certifier  (Check only one)  1 ™ Certifying Ph 2 □ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occuri ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ice, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the caus	e(s)
Σ	29b. Signature and title of certifier	4 ~ ^ ^		29c. License number	29d.	Date signed (Mon	th, Day, Year,	)
	Fines J	Wheaten	mo	D5863	9 a	pul 17,	200	8
	On Many and Landsham of the Committee of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4:00

Birthplace (State or Foreign Country)

white

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 20 No

DHMH 17 Rev 1/2001

State

Registrar

Aimee

31. Date filed (Month, Day, Year)

6701 N. Charles Street Boutumou MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

F. Wheaton MD

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 20b-c, per FH, G879, 5/7/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** HIAWATHA 1230 PM DULLEN APRIL 16 200 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 3ex 1 M 2 F **Funeral** Year) 938 Days Hours 212-36-5615 Director Usuai Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at MD 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code USA oshone Wa Funeral Was Decedent Ever in Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) the traumatic event. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic every ပ 19a Informant's Name/Relation 19b. Mailing Address (Street and Number or Rural Route Number ndallstown, MDZ1103 20b. Place of Disposition ( 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a contrequence of) /Medical Examiner Depos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons vuence of) Examiner be executed burial-tran Due to (or as a consequence of): Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy certificate 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ို 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059736 April mo 2008 Ratur 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 HOSPITAL DEBORAH WATSON CITZRATFULK NORTHWEST 5401 OLD WURT RO AD 32/Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

5008

8

APR

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ıryland		artment of H		Mental Hy	- 4	2000	1000	1
		18	Registrar  1. Decedent's Name (First, Middle, Last	t)		Cei	illicate of t	Jealli	2. Date of De	Reg. No.	<u> </u>	3. Time of Deat	h U
+	Physici /Medic		Albert Parker	,					Apri (	Day	Year ZeoS	545 F	M
	Examir		4a. Facility Name (If not institution, give Johns Hapkins Bay)	street and number)	O Car	Ser	4b. City, Town, or		th	4c.	County of Deat	h	
Ber	Funeral		Social Security Number     6. Se		(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. (Month, Da	ıy, Year)	9. Birt	hplace (State or Foruntry)	e <i>ign</i>
	Director		220-68-2445 Usual Residence of Decedent	X W Z	50	Yrs.			Jan 21	, 195	8 Mai	yland	
	ryland how at		10a. State 10b. County			, Town or Lo						10d. Inside City Lin	
	8a-fs	ectol	MD		Ва	ltimon						1√ Yes 2□	No
	with the a or 2	Funeral Director	10e. Street and Number 3728 Elmora Avenu	10			10f. Zip Code 2121	3			zen of What Co JSA	untry?	
	death ms 23	nera	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No		14. Race - Ame		
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1  ☐ Yes 2X N If Yes, Give Year or Dates:	lo	1	1 ☐ Yes 2 🌠 No	Specify:	no Alcan, etc.)		Black, White	hite	
21215-0036	n 72 hoi "natura edical E	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	orking unk	16b. Kir	nd of Business/	Industry	unk
212	d withingiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)								
pu	should be filed within and Mental Hygiene. s marked other than ' umatic event, the Me	Be	17. Father's Name (First, Middle, Last) Charles Albert Pa	rkor					me (First, Middle		,		
Maryland	should Ind Men marker	2	19a. Informant's Name/Relationship (7)			19h Maili	ng Address (Street		a August			Zin Codo)	
Ma	nd 2 shoulth and 27 is married r trauma		Louis Melcher/fri				St. Helen			-			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Other (Specify,		ce	ace of Dispo	osition (Name of matory or other place	ì	Date		cation - City or		
Baltir	permit. Pag Department Important: I any Injury o		21. Sign to uneral sce cens		ctor		2. Name and Addrest tate Anat			. Bal	timore	Street	
			23a. Part Enter the disease, or comp	lications that caused	the death.		altimore, ter the mode of dyin			ırrest,		Approximate Interval Between	
	Physician		shock or heart failure. List only of Immediate cuse (Final disease or condition	a Page (1)		A F	ailure					Onset and Death	1
7	/Medical		resulting in death)	a. Due to (or is a			acquire						
	Examiner	J.	Sequentially list conditions,	b. Aven	N(a_							3 hours	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Live	V F	zilure	2					I Week	
o,	an and		resulting in death) Last	Due to (or as a	consequ							. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
68760,	icate be executed physician and s the burial-transit	dical		d									
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						2	23d. Date of del	livery	
P.O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth : 4□Pregnant at 9□Unknown			_Ectopic pregnancy ☐ Other (specify)				Month	Day Year	
	es that igned by be deta	by Ph	Part II. Other significant conditions co	ontributing to death bu	ıt not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death	?
ords	w require been sig should b								. 1	Yes 2[	□No 3□Pi	robably 4.20nkm	own
Records,	The law rate has be page 2 sh	Completed							24a. Was auto perf 127 Yes	psy ormed?	prior to death?	utopsy findings availacompletion of cause	able of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of De	eath (Check only	2□No one)	1 □Yes	20110	
or V	hys this	은	1 Yes 2 No	Hospital: 1 Inpatier		ER/Outpatie		4 Li Nursing	Home 5□Res			cify)	
on 0	ding I. After fune	tion:	27. Manner of Death  1. Natural 5 □ Pending  2 □ Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe	how injur	y occurred		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At hor :. (Specify	me, farm, st	reet, factory, office	_	28f. Location (	Street and wn, State	d Number or R	ural Route Number,	
_	To the Hospital or A within 24 hours after To the Funeral Direction place of the Completely filled in by	Medical Ce		/sician: To the best on tiner: On the basis of and manner star	examinat								
	orthe orthe	Mec	29b. Signature and title of certifier	and manner sta	uou.		29c. Licens	e number		29d. Dat	e signed (Moni	th, Day, Year)	
	->= O		1270				RES-	000		April	1 10,2	2008	
			30. Name and address of person who o				*						
			Jennifer Cheng 1	4.D. 49.40 32. <b>№</b> gistra	Eusk	an A	senue Ball	imure, 1	MD 2/27	<b>14</b>			
No.	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 8 71		o olyriat	& A	084						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timore DNG 8. Date of Birth (Month, Day, Year) Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Min 1 ☑ M 2 ☐ F Director 87 May 27, 484-03-9592 1920 Iowa Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane #406 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💢 No Specify Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, the one. salesperson marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clayton Allen Palmer Laura May Tubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy DiLeo/daughter 1505 Northwest 91st Terrace Gainesville, FL 32606 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Serv 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part shoc immediate e (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 2 □ No the 9□ Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 10 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ N 3□ DOA ဥ 1 Inpatient 2 □ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Nettiral

To the Hospital or Attending Physician: The law requires that the death certificate be executed 

Certification:

Medical

State

Registrar

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

	MA	L	1 sone	MYS	
Name end	address	(1)	erson who completed o	ause of deeth (Item 23a) (Type Pri	ir

31. Date filed (Month, Day, Year) APR 18 2008

29b. Signature and title of certifier

Megistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2008 Physician 01:00 A.M Philip Mario Prestianni April 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City 4103 Granite Avenue Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Maryland 90 June 10, 1917 217-12-6002 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Director Baltimore City Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number of 2 should be filed within 72 hours after death with thand Mental Hygiene. 21206 United States 4103 Granite Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? "natural", or items Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 □ Yes 2 🛣 No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other than "natu vent, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Optician 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bonsignor Basilia Signorino Prestianni ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Fallston, Maryland 900 Dellwood Dr. Mrs. Nancy G. Lawrence - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Gardens of Faith April 21,2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Michael E. Canapp Baltimore, MD 21214 Inc. <u>Leonard J. Ruck,</u> 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventricular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) enosclerotic Condiovascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed use as the burial-transi and r as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 1☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation s after deau. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homas S.Wilson MD 5601 Loch Raven Blud Baltimore MD 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 18 2008 Registrar

DHMH 17 Rev 1/2001

08-02845 Raymond Anthon	v Ri	Please Type	or Print in Black of Maryland	ack Inde / Departn	lible Inl	c. Ensure	e <b>All Copi</b> ed Mental H	<b>es Are Leg</b> i lygiene	ble.	5
,	1- R	For State			cate of L			Reg	, No.	3. Time of Death
Physicial Medical Examin		. Decedent's Name (First, Middle,La RAYMOND ANTHON	Y RIDDICK					April 11, 20		1815 hrs
Can 4	ľ	a. Facility Name (if not institution, gi St. Mary's Hospital	ve street and number)		1	. City, Town, or Leonardtow	Location of Deat		4c. County of St. Mary's	s
cuneral	•	Social Security Number 6. 5		e (In yrs. last b	irthday)	If Under 1 Yea				g. Birthplace (State or Foreign
Director	-	075-46-6578 1	X <sub>M</sub> 2 F	53	Yrs.			7-18-	1954	CountryNEW YORK
w any		Oa. State 10b. County 10b. CALVER	יתי	10c. City, Tov		n				10d. Inside City Limits  1 Yes 2 No
aryland 8a-f sho	Director	0e. Street and Number		БОЗТ		10f. Zip Code		10	g. Citizen of Wh	at Country?
ith the Maryland 23a or 28a-f show notified at once.		114-15 H.G. TR		- IIO	142 14/20	206		Specify Yes or No-	USA 14. Race	- American Indian, Black,
leath wi	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Armed Forces		If Ye	s, specify Cubar	n, Mexican, Puert		White	, etc.
s after d	ক	3 Widowed 4 Divorce 15. Decedent's Education (Specify	of If Yes, Give Year			Yes 2 X No	specify: ition (Give kind of	f work done	Specify: 16b. Kind of Bu	BLACK siness/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) -12-	College (1-4 or 5+		during mo	st of working life	e. DO NOT use re	etired)	CT.	ERGY
5-0036 led within 7 Hygiene. lother than	g .	17. Father's Name (First, Middle, La	st)			KIEDI		ne (First, Middle, M	laiden Surname	
21215 21215 21d be file 1 Mental Hy marked o	a	WILLIAM RIDD  19a. Informant's Name/Relationship			19b Mailing	Address (Stre		MARY THO		n, State, Zip Code)
MD 2  Id 2 shoul  slith and M  27 is m  aumatic	٩	KENNETH RIDDI	CK (BROTHER	(c)	155-	01 90th	AVE. A	PT 2R JAM	IAICA, N	EW YORK 11432
ore, feel and of Healt If item		20a. Method of Disposition  1 XBurial 2 Cremation	Removal from S	tate crer	natory or oth		4-	Date -19-2008		City or Town, State  GOES, MARYLAND
altimore, rmit. Pages I ar epartment of Hee portant: If ite lury or other tr		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	ense GLAD VS	SEWELL	PEXER 22. N	CLAVER ame and Addres	CEMETIERS as of Facility			OME, P.A.
		23a. Part I. Enter the disease, or co	A SU	velle death Do	14	51 DARE	S BEACH	RD. PRIN	CE FRED	FRICK MD 2067 art Approximate Interval
Physician /Medical		failure. List only due cause on	each line.  a. Atherosclerotic							Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a con							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):						
10 m	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
e executed sian and ial - transit	cal	UNPENDED	d					<del></del>		
Box 68760, e death certificate be extending physician cefor use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of pregna		tal death 3	Ectopic pre	gnancy	23d. Date o Month	f delivery Day Year
OX 68 eath certi attendin for use a	sicia	past 12 months?  1 Yes 2 No 9 Unknown		at time of death	=	her (Specify)				
O. Bo at the de d by the	L	Part II. Other significant condition		ath but not resi	ulting in the u	underlying cause	e given in Part I.			ribute to the cause of death?  Probably 4  Unknown
IS, P.O. quires that the en signed by uild be detach	ted by								an 24b.	Were autopsy findings available
Records,  The law requir fficate has been s	Completed					· <del></del>			rmed?	prior to completion of cause of death?  1 Yes 2 No
tal Recision: The certificate	Be Co	25. Was case referred to medical examiner?	Heepitel:				Other		Residence 6	Other:
of Viting Physic	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa  28a. Date of In (Month, Date)		R/Outpatient 28b. Time of		njury at Work?	28d. Describe	how injury occu	
ion (trending death.	ation	1 Natural 5 Pendir 2 Accident Investi	ng gation				Yes 2 No	29f Location	Street and Num	ber or Rural Route Number, City
Division of Vital la or Attending Physician. Tra sher death. "at Director: After this certiled in by the funeral director	Certification:	3 Suicide 6 Could 4 Homicide	not be	f Injury - At hon	ne, farm, stre	et, factory, office	e building, etc.	or Town,		
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be environ 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		29a Certifier	sician: To the best of iner:On the basis of e	my knowledge	e, death occu	rred at the time,	date and place,	and due to the cau	se(s) and mann and place, and	er as stated. due to the cause(s)
To the comp	Medical	29b. Signature and title of certifier	and manner state	ed		29c. Lice	ense number		29d. Date sig	ned (Month, Day, Year)
		2	/ Cant			0.0	C.M.E.		April 12, 2	2008
- B		30. Name and address of person v David Fowler M.D. C	who completed cause of the completed cause of the cause o		11 Penn S	Street, Baltin	nore, MD 212	201		
S Regis	tate	7(1)(1) 7 (1)	2008 32 R	strar's Signatur	K A	and is				
	274		-		ODICINA	NI.				

DHMH 17 Rev 1/2001 OCME 2006

	Baltimore, Ma
•	
	Division or Vital Records, P.O. Box 68760,

							<b>delible Ink.</b> artment of F	. Ensure A lealth and N	-		gible.	
		For State Registrar				•	tificate of			Reg. No.	800	12664
Physicia /Medic		1. Decedent's Name (First, Mi William Ree							2. Date of Dea Month	Day 30	Year 2008	3. Time of Death  9:00 ρ M
Examin		4a. Facility Name (If not institu	tion, give stree	t and number)	)		**	r Location of Death		4c. Cou	unty of Death	
		Future Care 1 5. Social Security Number	Lochear:		ge (In yrs. last	hirthday)	Balt If Under 1 Year	imore If Under 24 Hrs.	8 Date of Birt	h	9 Right	nplace (State or Foreign
Funeral Director	8	213-30-5575 Usual Residence of Decedent	1 X M		77	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day June 7	, Year) , 1930	Cor	yland
aryland show d at	_	10a. State 10b. Cou	nty		10c. City, To							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M 28a-f notifie	recto	10e. Street and Number			Dait.	THIOTE	10f. Zip Code			10a Citizen	of What Cou	41
h with	Funeral Director	4800 Seton Dr	ive					1215			USA	,.
ems ?	ıner	11. Marital Status	12. V	vas Decedent	Ever in U.S.	13. \	Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)		Race - Amer Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2	larried 1	∏Yes 2 <b>X</b> Yes, Give ear or Dates:			1□Yes 2X No	Specify:	,			lack
72 ho "natur dical	Completed	15. Dece (Specify only hig	dent's Education		16	(Give	dent's Usual Occup	during most of work	unk king l	16b. Kind o	of Business/I	ndustry
within lene. than the Me	dmc	Elementary/Secondary (0-1:	2) (	ollege (1-4or	5+)	iite. L	DO NOT use retired	a)		law	m care	2
al Hygi other vent, t	Be C	17. Father's Name (First, Midd	lle, Last)					18. Mother's Nam	ne (First, Middle,			
Menta Menta arked aric e	To	James Reed						Christi	ne Thom	oson		
d 2 shoth and 7 is m		19a. Informant's Name/Relation Sharon Green/		,	1			and Number or Ru				
tem 2		20a. Method of Disposition	caregiv	rer	20b. Place	of Dispo	sition (Name of	nd Lane I	Date		2120 on - City or 1	*
t. Pages tment of tant: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📉 Othe	(Specify) i	n, state			natory or other plac					
permi Depar Impor any Ir		21. Sig The Ronal of Ronal of	1/13	ack	-	Ba	ltimore.	ess of Facility Omy Board MD 2120	01_		imore	Street
Physician /Medical Examiner prize and prize transit pri prize transit prize transit prize transit pr	Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediat Cause (Final disease or ondition resulting in leath)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or in	List only one ca	USE ON EACH I	AGE PLES a consequence NTE NS a consequence	ce of):	L FAILUR		or respiratory at	Test,		Approximate Interval Between Onset and Death
ber icia	7	resulting in death) Last	d	Due to (or as	a consequenc	ce of):						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	Live birth	e pf pregnancy 2 □ Fetal dea at time of death	ath 3□	]Ectopic pregnanc; ]Other (specify) _	у		23d.	. Date of deli Month	very Day Year
uires that signed t d be deta	by	Part II. Other significant con-	ditions contribu	ting to death t	out not resulting	g in the ur	nderlying cause giv	ren in Part I.				the cause of death?
s been should	lete								24a. Was	an 2	4b. Were au	topsy findings available
/sician: The law s certificate has t lirector, page 2 s	Completed								autor perfo 1∐ Yes	rmed? 2□No	prior to c death? 1 ☐ Yes	ompletion of cause of
siciar certif	o Be	25. Was case referred to med examiner?  1 ☐ Yes 2 ☑ No	ical Hospi	tal:	ent 2 ☐ ER/	Outnation	t 3D DOA Oth	26. Place of Dea			lou (0	~ .
ing Phy I. After this funeral d	$\vdash$	27. Manner of Death 1 ☑ Natural 5 ☐ Per	nding	Ba. Date of Injuly (Month, Da	ury 28t	b. Time of Injury	28c. Injur Wor		ome 5 ☐ Residence 1			eny)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Certification:	3 Suicide 6 Cou	estigation uld not be ermined 28	Be. Place of in building, e	jury - At home, tc. (Specify)	, farm, str	eet, factory, office	163 2 10	28f. Location (S City or Tox		umber or Ru	ral Route Number,
Hospita 24 hours Funeral stely filled	Medical C		cal Examiner:		of examination			me, date and place opinion, death occu				
To the within To the compli	Me	29b. Signature and title of cer		^	hysicar	7	29c. Licens	se number 4593/		29d. Date si	igned (Month	
	+	30. Name and address of pers			•					April	11, 2	008
		Doborah I Pie	erce s	15 MA1.	N STRE	ZT	KH STURS	TOWN M	D			
Sta Registr		31. Date filed (Month, Day, Ye APR ]	8 2008	32. Regist	rar's Signature	B	range					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Maryland / D	ера		of H	lealth and N	fental Hyg	•	_	12565	
			Decedent's Name (First, Middle, Las						2. Date of Dea	ıth		3. Time of Death	
>	Physici /Medio Examir	al	Derrick D. Ramber			4b. City, T	own, o	r Location of Death	April 4	7	Year B nty of Death	9:20 AM M	
	CAUTIII		828 Reverdy Road					nore					
	Funeral		5. Social Security Number 6. Se		day)	If Under 1	1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day)	h ( Year)	9. Birth	nplace (State or Foreign	
	Director		218-92-5699 Usual Residence of Decedent	ZM 2□F 40 Y	rs.	Wioriurs	Days	Tiodis Ivial.	Dec 12	, T967	Nort	h"Carolina	
	land ow		10a. State 10b. County	10c. City, Town	or Lo	ocation						10d. Inside City Limits	
	Many a-f eh	tor	MD	Balt	tin	nore						1√∑Yes 2 ☐ No	
	vith the Maryland of or 28a-f ehow	irec	10e. Street and Number			10f. Zip (	Code			10g. Citizen	of What Cor	untry?	
	ath wi	raic	828 Reverdy Road					21212			USA		
21215-0036	72 hours after death with the Maryland natural, or iteme 23a or 28a-f show idical Examiner must be notified at	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes. 2 ☒ No If Yes, Give Year or Dates:		Was Decede II Yes, speci 1 Yes 2		ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	1	Race - Amer Black, White cify: b1	•	
5-0	72 hours "natural",	eted	15. Decedent's Edi (Specify only highest grad	ucation 16a. I	Dece	dent's Usual	Occup	ation	rina	16b. Kind of	Business/I	ndustry	
121		To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired	during most of work 1)	9	£ : .	•	1	
d 2	filed v Hygia ther t	ပိ	17. Father's Name (First, Middle, Last)	3				18. Mother's Nam	e (First Middle		nancia	a L	
an	id be entat ked o	o Be	Freddice Lee Ramb	ert				Theresa		madon ban	arrio,		
Maryland	nd 2 should be filled within and Mental Hygiane. 27 is marked other than rtraumatic event, the Mental traumatic event.	-	19a. Informant's Name/Relationship (7) Theresa Jones/mot					and Number or Rui				ip Code)	
Baltimore,	nit. Pages 1 end 2 should be filed within carment of Heelih and Mental Hygiane. ortant: if item 27 is marked other than injury or other traumatic event, the Me.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	nemoval from State	Dispo , crer	osition (Name matory or oth	e of her plac	ee)	Date	20c. Locatio	on - City or 1	Fown, State	
Balt	permit. Page Department of Important: if any injury or once.		21. Sign to all Scot Sicensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
	Physician /Medical Examiner	ner	23a. Part . Enter the disease, or comp shock, or heart failure. List only commediate Sause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events	a. AIDS  Due to (or as a consequence of Pancal  Due to for as a consequence of the conseq	):	er the mode	of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
3760,	icate be executed physicien and s the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of d.	): ~?.	ulu ce	re 41	iuse					
P.O. Box 68	The lew requires that the daath certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pre Other (spe				4	Date of deli	very Day Year	
	es that igned to be det	by P	Part II. Other significant conditions co	ntributing to death but not resulting in t	the u	nderlying ca	use giv	en in Part I.	23e. Did to	bacco use co	ontribute to	the cause of death?	
ord	w require been sig should b	pe	Bipolar	disorder		_			1 🗆 Y	es 2000	3 □ Pro	bably 4 Unknown	
of Vital Records,		Completed	Personalir	ry disorder					24a. Was autop perfor 1 Yes	sv	prior to c death?	topsy lindings available ompletion of cause of	
N E	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat					
o	Phys r this ral di	2	1 Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outp  28a. Date of Injury 28b. Tir			·	4   Nursing no	ome 5 Resid			ufy)	
o	Attending r death. sctor: After by the fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ury	M 20	C. Injun Worl	k? Yes 2 □ No	200. Describe ii	Ow injuly occ	Surred .		
Division	i or Atter efter dea i Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, str	reet, factory,			28f. Location (S City or Tow	itreet and Nu n, State)	mber or Ru	ral Route Number,	
	To the Hospital or Attending f within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer	Medical C	29a. Certifier (Check only one) 12 Certifying Phyone) 2 Medical Exam	sician: To the best of my knowledge, iner: On the basis of examination and/ and manner stated.	death or in	h occurred a vestigation, i	it tha tin in my o	ne date and slace pinion, death occur	and dua to the cred at the time, o	taves(s) and date and place	Tamer as e, and due	etated to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	Richie MD		29c.		number		9d. Date sig			
			> Zmily					3704			4/11/		
			30. Name and address of person who c	ompleted cause of death (Item 23a) (The MD Cha	ype, کی ح	Print) e Bre	xte	n HS.	1001 C			St. Balt,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		B .0						21201	

Registrar

APR 1 8 2008

4a 5. Us 100 M. 100 111	a. Facility Name (If not institution, given STELLA MARIS HOS Social Security Number 6. Security Number 6. Security Number 1214-18-7775  Sual Residence of Decedent 10b. County 10b. County 10b. Street and Number 1900 Eutaw Place 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Editor only highest grass Elementary/Secondary (0-12) 12  7. Father's Name (First, Middle, Last)	FERGUSON R. e street and number) PICE  Sex 7. Age  12. Was Decedent E Armed Forces? 1   Yes 2   New Year or Dates: ducation and completed)	(In yrs. last to 91 10c. City, To Ba]	Certific  4b. (  4b. (	City, Town, o  Timol Inder 1 Year Iths Days  City f. Zip Code	r Location of Death  nium  If Under 24 Hrs.  Hours Min.	2. Date of De Month April  8. Date of Bir (Month, De	Reg. No. 2 (ath Day 15, 2( 4c. Coun Balti	9. Birthpi Coun Mary	0d. Inside City Limi 1 X Yes 2 □ N	
4a 5. Us 100 M. 100 111	EMMA BIRD  a. Facility Name (If not institution, given STELLA MARIS HOS Social Security Number 6. S. 214-18-7775  Sual Residence of Decedent 10b. County 10b. State 10b. County 10b. Street and Number 1900 Eutaw Place 1. Marital Status 1 Never Married 2 Married 15. Decedent's Edition (Specify only highest graft Elementary/Secondary (0-12) 12  7. Father's Name (First, Middle, Last)	FERGUSON R. e street and number) PICE  Sex 7. Age  12. Was Decedent E Armed Forces? 1   Yes 2   New Year or Dates: ducation and completed)	(In yrs. last to 91 and 10c. City, To Ba] ver in U.S.	4b. (  which or continues the second	Timol Inder 1 Year Iths Days  City f. Zip Code	nium If Under 24 Hrs. Hours Min.	Month April  8. Date of Bir (Month, Da	15, 20 4c. Coun Balti	ty of Death  MOTE  9. Birthpi Coun  Mary	4:35 P  County lace (State or Fore try)  Land  Old. Inside City Limi  1 X Yes 2 \( \)	
5. Us 10 M. 10 11 11 11 11 11 11 11 11 11 11 11 11	a. Facility Name (If not institution, given STELLA MARIS HOS Social Security Number 6. Security Number 6. Security Number 1214-18-7775  Sual Residence of Decedent 10b. County 10b. County 10b. Street and Number 1900 Eutaw Place 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Editor only highest grass Elementary/Secondary (0-12) 12  7. Father's Name (First, Middle, Last)	PICE  Sex 7. Age  The street and number)  PICE  The street and number of the street and number o	(In yrs. last to 91 and 10c. City, To Ba] ver in U.S.	4b. (  which or continues the second	Timol Inder 1 Year Iths Days  City f. Zip Code	nium If Under 24 Hrs. Hours Min.	8. Date of Bir	4c. Coun Balti th ky, Year) 7, 1917	more 9. Birthpi Coun Mary	County lace (State or Fore try) Land Od. Inside City Limi 1 NYes 2 \( \text{\te}\text{\texi{\text{\text{\texi{\texi{\texi{\texi\texiet{\texi{\texi{\tex{\texict{\texict{\texi{\texiet{\texi{\texie\texi{\texie\texi{\tex	
110 M. 111 117 117 117 117 117 117 117 117 11	Social Security Number  214-18-7775  sual Residence of Decedent  Da. State  10b. County  aryland  N/A  De. Street and Number  1900 Eutaw Place  1. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)	7. Age  12. Was Decedent E Armed Forces? 1   Yes 2   Ni If Yes, Give Y year or Dates:  ducation ade completed)	91 10c. City, Tor Bal	wn or Location Ltimore	nder 1 Year nths Days  City f. Zip Code	If Under 24 Hrs. Hours Min.	(Month, Da	th ly, Yea <i>r)</i> 7, 1917	9. Birthpi Coun Mary	lace (State or Fore try) Land  Od. Inside City Limi  1 ∑Yes 2 □ N	
10 M. 10 11 11 11 11 11 11 11 11 11 11 11 11	214-18-///5     Sual Residence of Decedent     Da. State	12. Was Decedent E Armed Forces? 1	Ba]	wn or Location	City f. Zip Code			, 1917	Mary	'Land od. Inside City Limi 1 X Yes 2 □ N	
M. 10	aryland N/A De. Street and Number  1900 Eutaw Place  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)	12. Was Decedent E Armed Forces?  1	Ba]	Ltimore 10f	City f. Zip Code 21	04.7		10g. Citizen o		1 X Yes 2 □ N	
111	1900 Eutaw Place  1900 Eutaw Place  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)	12. Was Decedent E Armed Forces?  1	ver in U.S.	10f	f. Zip Cođe <u>21</u>	04.7		10a. Citizen o			
17	I. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's Erectly only highest grade Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)	12. Was Decedent E Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: ducation ade completed)	0	13. Was D	Maryland N/A Baltimore City  10e. Street and Number  1900 Eutaw Place  11. Marital Status  1 □ Never Married 2 □ Married						
17	1 Never Married 2 Married 3 N Widowed 4 Divorced  15. Decedent's Er (Specify only highest gra  Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last)	Armed Forces?  1	0	If Yes,	ecedent of Hispanic Origin? (Specify Yes or Napecify Cuban, Mexican, Puerto Rican, etc.)		necify Yes or No	USA 14. Race - America		an Indian	
17	(Specify only highest gra  Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)	ide completed)		1 □Ye	specify Cuba s 2⊠No	an, Mexican, Puerto Specify:	Rican, etc.)	Spec	ack, White, e		
17	7. Father's Name (First, Middle, Last)					eation during most of work d)	ring	16b. Kind of	Kind of Business/Industry		
L				xecutiv	ve Sec		· (Final Beinful)		l Offi	ces	
1:	Joseph Irving Bi					18. Mother's Nam	ce Elis		ŕ		
	9a. Informant's Name/Relationship (	Type. Print)		-		and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	,	
20	Mr. John S. Reve						timore,				
	4 Donation 5 Other (Specification)	y)	1	n Mount	Cemet	ery 4/19					
2		anser!		22 Nam MIT(	e and Addre	WIEDEFELD	FUNERA	L HOME	INC.	1010	
ir di re	shock, or heart failure. List only mmediate Cause (Final isease or condition esulting in death)	a. DEMENTIA  Due to (or as a	consequence	e of):	mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
113	at initiated events	CDue to (or as a	consequence	e of):							
		1 Live birth 2	Fetal dea			у				ery Day Year	
Pa	art II. Other significant conditions o	ontributing to death but	not resulting	in the underlyi	ng cause giv	en in Part I.					
-	·····									, A.	
Γ							autor	osy ormed?	prior to con death?	npletion of cause o	
25	examiner?	Hospital:	. a 🗆 s n /	Dudu ation 4 2 0	Oth		h (Check only o	ne)		- III	
27	7. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,	28b.		28c. Injur Worl	y at k?				) HOSPICE	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	y - At home, (Specify)	farm, street, fac	ctory, office		28f. Location (: City or To	Street and Nun vn, State)	nber or Aural	Route Number,	
29	9a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	niner: On the basis of	examination a	ge, death occur and/or investiga	rred at the til ation, in my o	me, date and place pinion, death occui	and due to the red at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)	
29	9b. Signature and title of certifier	)			29c. Licens	e number		/ 1			
20	Name and address of person who	Completed cause of de-	ath /lear ag-	\(Tune Date)	DI	13725		4/1	6/0,	8	
		2300 DUL	ANEY V		יי תם	TMONTIM	WD 2100	13			
	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 X Burial 2 Cremation 3 A Donation 5 Other (Specification of Control of Cont	1	Creen	Creen Mount   Creen Mount	21. Signatur of Finery Servi Cooperations state and provided the provided of t	1   Secretary   Commeters   Commeters	Creen Mount Cemetery 4/19/2008   Creen Mount Cemetery 4/19/2008	## ADDITIONAL SIGNATURE (Specify)    Complete the disease, or completed to the death. Do not enter the mode of dying, such as cardac or respiratory arrest.	Committed   Comm	

DHMH 17 Rev 1/2001

08-02794

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Steven Richards Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1753 hrs April 9, 2008 Medical Examiner Steven Richards 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Months Days 12/13/2000 Director 217-59-3511 7 2 F 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Glen Burnie 23a or 28a-f show notified at once. Anne Arundel Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 706 Hamlen Road 运 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Yes White Specify 4 Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed ð 6b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) N/A 21215-0036 Student Compl 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennifer Abbott Titchenell Ron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ٥ 706 Hamlen Road, Glen Burnie, MD 21061 timore, MD Jennifer Titchenell (mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 2008 Glen Haven Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Sign were of Funeral Service Ocenses 3111 Mountain Road. Pasadena. Approximate Interval peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or co Between Onset and Physician List only one cause on each line Death /Médica a. Head and Torso Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical AMENDED UNPENDED is been signed by the attending physician should be detached for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown ð Completed 24a. Was an 24b. Were autopsy findings available of Vital Records, prior to completion of cause of autopsy death? performed? has ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: æ Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA this 1 🗸 Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month Day, Year) Apr 9, 2008 28b. Time of injury After 27. Manner of Death tree branch fell on subject Certification: 1700 hrs Yes 2 🗸 No Natural Division 5 Pending death. Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire or Town, State) 7962 Telegraph Road, Severn, MD 6 Could not be 3 Suicide determined (Specify) Driveway of residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature And title of certifi-April 10, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner State 2008

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a State of Maryland / Department of Health and Mental Hygiene Per INF 8879 5/06/08 if Hate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year **Physician** 2008 /Medical Bult1 . Facility Name (If not institution, give 4b. City, Town, or Location of Death **Examiner** CYC Micd Da If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 216-32-9073 72 1-6-1936 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Yos 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Examiner must be 2609 Fairview Avenue 21215 U S Α · death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status filed within 72 hours after 1 □ Yes 2 □ No If Yes, GiveX Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black þ 3 Widowed Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Madical 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) the Cook N/A <u>Meridian N/H</u> 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 Is marked o Pages 1 and 2 should be Will Caldwell Alice Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latonya Greer - Daughter 2609 Fairview Avenue Balto, MD 21215 Department of Heal Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XIXBurial 2 □ Cremation 3 □ Removal from State Carmel Cemetery 4-18-2008 Balto, 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H lad 1101 E. North Avenue Balto, MD 21202 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wee /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician at s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe page death? certificate 2 □ No 1□ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours after To the Funeral Dire

who completed cause of death (Item 23a) (Type, Print) e and address of persor 5 Registrar's Signature State Registrar

29b. Signature and title of pertifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. amend item 4a per doc 8878 4-18-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 APRIL **Physician** KAREN SMITH 10:04 /Medical 4a. Tooling Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 757 DRUID PARK LAKE DRIVE APTIZA MI BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 ☐ F Director 213-88-2839 06/12/1967 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 727 Druid Park Lake Drive Apt. 12A Funeral 21217 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗓 No څ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Day Care Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Ruth Henry Daniel A. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel A. Smith / Father 3730 W. Garrison Avenue, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park Ceme, 04/21/2008 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HYDROCEPHALUS **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BRAIN TUMOR YEARS Sequentially list conditions, if any, leading to infine drate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 kunknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HY PERTENSION Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 Tes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

4120 PATTERSON Are, 31. Date filed (Month, Day, Year) APR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

BALTIMORE MD 21215

Do0 64369

APRIL 16, 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of State of Maryland / Department of Certificate of Certi		al Hygiene Reg. No. 2001	8 12670
	Discorder		1. Decedent's Name (First, Middle, Last)		te of Death	3. Time of Death
	Physici /Medic		Gerard James Smigle	AF	Pril 17 2008	12:35 PM
	Examin	er		n, or Location of Death	4c. County of Dea	
7		щ	Franklin Square Hospital center Kosco			more
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day 76	ys Hours Min. (Mo	te of Birth onth, Day, Year)  9. Bir C  12/11/1931 MD	rthplace (State or Foreign ountry)
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	laryla sho	5				1 Tyes 2 No
	death with the Maryland rms 23a or 28a-f show f must be nottined at	Director	MD Baltimore City Baltimore  10e. Street and Number 10f. Zip Cod	Δ	10g. Citizen of What C	
	aa or					outing.
	death ms 2	Funeral	5632 Whitby Road         2120           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent Company in U.S.	of Hispanic Origin? (Specify Ye	USA es or No- 14. Race - Am	erican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2 → Married 1 □ Never Married 2 → Married 1 □ Yes, Sive 1 □ Yes 2 → Year or Dates: 1950 − 1958	cuban, Mexican, Puerto Rican,	etc.) Black, Whit	hite
2-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Oc	cupation	16b. Kind of Business	
2121	12 should be filed within 7 h and Mental Hyglene. 7 is marked other than "r traumatic event, the Med	du de	Elementary/Secondary (0-12) College (1-4or 5+)	ne during most of working tired)	Health Ca	are
2	led wi		2 Cashier			
Maryland	lbe fi ntal H ed ot ever	Be	17. Father's Name (First, Middle, Last)	1	Middle, Maiden Surname)	
<u>`</u> Ë	hould Id Me mark matic	ပ္	Louis Smigle  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stra		nillips e Number, City or Town, State,	7. 0. 4.1
Ma	id 2 s Ith ar 27 is trau					ZIP Code)
<b>a</b>	f Hea		20a. Method of Disposition 20b. Place of Disposition (Name of	y Road Baltimo	20c. Location - City or	Town, State
ê.	Pages ent of ht: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Change of the Cha	Ap:	r 19	
altimore,	mit. I Sortan 7 Inju		21. Signature of Funeral Service Licensee Chesapeake Cre		08   BelfsAllie	e, Maryland
Ö	Depa Impo any Ir		Crematic	on and Funeral A		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.	dying, such as cardiac or respi	ive Baltimore, ratory arrest,	Maryland 21286 Approximate Interval Between
	Physician			ardovasalor	Discuse	Onset and Death
	/Medical		resulting in death)  a. Due to (or es a consequence of):	QV 2000 #160 @0	A Mac N TC	Jans
	Examiner		Sequentially list conditions, b.			
_	sit 9d	iner	day, lesses er injury  Due to (or as a consequence or).  Cause (Disease or injury)			
V	and -trans	Examin	that initiated events			
60,	be ey Ician burial		Due to (or as a consequence of):			
68760,	phys phys s the	edical	d			
×	certif nding se as	NE S	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	Nivery
Box	death atter	ciar	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnated in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify, other		Month	Day Year
P.0.	t the c by the ached	Physician/M	9 ☐ Unknown	,		
ď.	s tha	by P	Part II. Other significent conditions contributing to death but not resulting in the underlying cause	given in Part I. 23	Be. Did tobacco use contribute t	to the cause of death?
of Vital Records,	en sig	pa	Teripheral Vacaber Wiscase		1 ☐ Yes 2 No 3 ☐ F	Probably 4 Unknown
ecc	law re as be 2 sho	Completed	Hypertention	24	la. Was an 24b. Were a	utopsy findings available completion of cause of
<u> </u>	The ate h	ĕ	. 11	1[	performed? death?	s 2 No
/ita	clan: ertific ector,	Be (	25. Was case referred to medical examiner?	26. Place of Death (Chec		
£	hyst this o	ပ္	I impatient 2 En/Outpatient 3   BOA		☐ Residence 6 ☐ Other (Spe	ecify)
n O	After Uner	ion:		Vork?	escribe how injury occurred	
isio	ttend death stor:	icat	3 Suicide 6 Could not be 290 Blood of Injury At home form about 6 to the officer	☐Yes 2☐No		
Division	after Direc	Certification:	determined    See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation <i>(Str</i> eet and Number or Fi ly or Town, State)	Rural Houte Number,
_	spital ours neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place, and du	e to the cause(s) and manner a	as stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  2☐ Medical Exeminer: On the basis of examination and/or investigation, in mand manner stated.	ny opinion, death occurred at the	ne time, date and place, and du	e to the cause(s)
4	Nithii North	M	29b. Signature and title of certifier 29c. Lice	ense number	29d. Date signed (Mon	th, Day, Year)
				1 1 1 11		
	\		M S UL W D	41614	APRIL IS	800g
	141		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		APRIL 18	3, 2008
_	∩ <sup>X\</sup>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A lay Lay (W) 4920 Cary Level  31. Date filed (Month, Day, Year)  32. Registrars Signature		APRIL 18	3, 2008 3, 2008

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Constance Selby Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 14, 2008 0707 hrs Medical Examiner Constance Barbara 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Essex 4 Printe Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. Davs April 7, 1952 Director 213-60-3905 Maryland 1 M 2 XF 56 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State any 1 Yes 2 X No Baltimore Essex MD. 28a-f show notified at once. death with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number 4 Punte Lane 21221 USA 238 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes White hours after Yes 2 X No specify: Specify: 4 X Divorced If Yes, Give Year If item 27 is marked other than "natural", her tranmatic event, the Medical Examiner. 3 Widowed ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Upper Chesapeake Elementary/Secondary (0-12) College (1-4 or 5+) Dietary Manager Baltimore, MD 21215-0036 Medical Center Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter George Fedo Albina Krocheski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Wyton Road Towson, MD. 21286 Albina Fedo/ Mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Burial 2 X Cremation 3 Evans Funeral 04/16/08 Forest Hill, MD. Removal from State Chapel-Donation 5 Other Specify. Bel 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 Signature of Funeral Service Licensee Approximate Interval art I. Enfer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease caminer condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical physician a AMENDED UNPENDED Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed' death? ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) 25 Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: e Hospien. ... n 24 hours after death. ... he Funeral Director: A 1 V Natural Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier April 14, 2008 O.C.M.E.

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registra

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2008

Ana Rubio MD. 31. Date filed (Month,

Assistant Medical Examiner

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM#31, perDWR., 68/8, 4/18/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 4:40 a. M **Physician** 04 mm 2 - 20 0/8 Daisy Spencer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1328 W. Lafayette Ave | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 9 - 0 7 - 1 9 1 9 Birthplace (State or Foreign Country)
 C • Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1□M 2□F 88 220-24-9837 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Baltimore Director 1 ☐Yes 2 ☐ No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A. 1328 W. Lafayette Ave. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify:Black Baltimore, Maryland 21215-0036 "natural", or Specify. <u>ک</u> 3 Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

MiQWlie College (1-4or 5+) Private permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Goins Samuel Knotts 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1328 W. Lafayette Ave. Baltimore, Md 21217 Avis Foote/Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition King Memorial PK. 4-18-2008 Woodlawn, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility: $f Ronald\ Taylor\ II\ Funeral\ HM$ 108 W. North Ave. Baltimore, Md 21201 mona 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as an insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner The law requires that the death certificate be executed burial-tran and Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 ☑ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Abesidence 6 Other (Specify) 1 Yes 27 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29d. Date signed (Mghth, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 18 2008 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend #1&5 Per Phy & FH G8784/18/08 TH Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Loretta Smith /Medical 4a. Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Balt nwe,
If Under 1 Year If Under 24 Hrs. d Samaritan Nusing Center 6000 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ? Is marked other then "natural", or flems 23s or 28s-f show treumatic event, its Medical Examinar must be rediffied at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2120 672 USA Road ton . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Admin istrata ayrs layrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fi tment of Heelth and Mental F tant: If Item 27 Is marked of Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWYM OOK, MO ZIZOT Husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Dwings Hills, MD 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Randallstown, MD 2183 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ysiclen and e burial-transit Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes or Attending Physicien: tor: After this cartific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1/SuNatural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) vd ni bellij 4 Homicide within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lo Ch Laveu 1210 ; 560 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 8 20 State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Scott 9:50AM Harry 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 218-42-5322 1 ☑ M 2 ☐ F Director 4-5-1947 MD Usual Residence of Decedent show i 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director MD N/A X∑Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5822 Moores Run Court 21206 S Α 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 N/AElementary/Secondary (0-12) College (1-4or 5+) Unemployed h and Mental Hygien 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked tany or other traumatic even ည Harry J. Scott, Sr Daisy Burrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard I. Scott-Brother 5813 Waycross Road Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-19- 08 Baltimore, MD Garden of Faith: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East ady K Wanes 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician anoxic brain injury /Medical Due to (or as a consequence of): Examiner Ventricular fibrillation Cardiac arrest
Due to (or as a consequence of): Sequentiary life concurre, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed myocardial infarction and Due to (of as a consequence of) Box 68760, physician Physician/Medical the attending nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 autopsy performed' certificate or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Division Hospital or Attending 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No death 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

T. Woretze, MD

TINSAY Woreta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Street Baltimore, MP 21287

	02756 one Smith		R	State For State egistrar	or Print in BI e of Maryland	/ Departi		Ith and Mental	Hygiene	Reg. No.		3 1267
Ö	Physiodical Exar		4	. Decedent's Name (First, Middle,L			a		2. Date of I	Day	Year	3. Time of Death 1043 hrs
lyte	micai Exar	nine		la. Facility Name (if not institution, o	Tyro		Smith 4b. City.	Town, or Location of D	April 8,		inty of Death	10401110
<b>.</b>				Harbor Hospital	give object and named,			more			,	
	Funera Directo			,	Sex 7. Ag	e (in yrs. last i		der 1 Year If Under 24 hs Days Hours	1.4%	Birth (MM/DD/)	Cou	place (State or Foreign ntry) MD
	·y·	1	_	Usual Residence of Decedent		100 City To	wn or Location					10d. Inside City Limits
	ow any	1	1	MD 10a. State 10b. County	N/A		timore					1 Yes 2 No
	ryland a-f sh		<u>3</u>  -	10e. Street and Number	N/A	Dai		p Code		es or No- etc.)  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Black  Specify:  16b. Kind of Business/Industry  Middle, Maiden Surname)	2121	
	or 28		<u></u>	1740 Montpelie	er Stree	t		21218		US	A	
7	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show		niei ai	11. Marital Status 1 X Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? 1 Yes 2 ed If Yes, Give Year or Dates:		If Yes, spec	lent of Hispanic Origin? ify Cuban, Mexican, Pu 2 No specify:		,	White, etc. B	
1	oours a		֓֟֟֝֓֓֓֟֟֓֓֓֓֓֟֟֓֓֓֓֓֟֟֓֓֓֓֓֓֓֓֓֟֟֓֓֓֓֡֟֝֓֡֡֡֡֡֡֡֡	15. Decedent's Education (Specify	only highest grade cor			I Occupation (Give kind orking life, DO NOT use		16b. Kind	of Business/Ir	idustry N/A
	36 n 72 h		naiaidiiioo	Elementary/Secondary (0-12)	College (1-4 or		Ü		, , , , , , , , , , , , , , , , , , , ,			
	5-0036 iled within 7. Hygiene.		<u></u>	9th grade  17. Father's Name (First, Middle, La	N N	/A	Disable		lame (First, Midd	lle. Maiden Surr	name)	
	215 e filec tal Hy	Cyclif,		Paul Smith	,				C. Wo		,	
	21.			19a. Informant's Name/Relationship	(Type, Print)	- 1	19b. Mailing Addres	S (Street and Numbe	r or Rural Route	Number, City or	Town, State,	Zip Code)
	MD d 2 shc lth and n 27 is	F	I	Michael Smith-	-Brother		1740 Mor	tpelier		Balt	o, MD	21218
	ore, s l an of Hea If iter			20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from St		ce of Disposition (Na matory or other place	e)	Date		tion - City or	
	Baltimore, permit. Pages 1 ar Department of Her Important; If ite	5 I		4 Donation 5 Other Spec	ify:	Gre	enmount		-18-20	08 Bal	timor	e, MD
	Salt ermit. Depart mpor			21. Signature of Funeral Service Lic	ensee		22. Name an	d Address of Facility	March	-	East	
			+	23a. Part I. Enter the disease, or co	mplications that caused	the death. Do	not enter the mode	) 1 E. No	rth Ave	arrest, shock,	Balto or heart	MD 2120
	Physicia 'Medic xamine	al :	1	failure. List only one cause on		hythmia						Between Onset and Death
		ı	1	Sequentially list conditions,	b.	oquonoo on						
				if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of):						
		ed for use as the burial - transit  hysician/Medical Examiner	LXal	events resulting in death) Last	Due to (or as a cons	equence of):						
	e executed			X UNPENDED	d амендер 23а	,Pt.II,2	7, per ME g	878 4/29/08 a	mh			
	760 icate b			IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outco	me of pregnar					ate of delivery	
	certif	SE ds		b past 12 months?  Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Pregnant at time of death  5 Other (Specify)								ay Year
	Box death	loi n	ış l	1 Yes 2 No 9 Unkno			o Other (op			-		
	Division of Vital Records, P.O. Box 68760, spiral or Attending Physician: The law requires that the death certificate be hours after death.  neral Director: After this certificate has been signed by the attending physici	netacine	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause and the contribution of the cause o									the cause of death?
	15, I	and big	nered	Asthma:HIV Seropo	SILIVILY							topsy findings available
	Orc law re	Olis 7							a	utopsy erformed?		ompletion of cause of
	Re( The	bage	E COMP						1 🗸 Y	es 2 No	1 🗸 Ye	s 2 No
	ital ician:	0000	6	25. Was case referred to medical examiner?	Hospital: 1 Inpatio	ant 2 🗗 🗂	R/Outpatient 3	26.Place of Death (Cl	neck only one)  Jursing Home 5	Residence	6 Other	
	of V ; Phys	E L		1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ury 2	Bb. Time of Injury	28c. Injury at Work?		ribe how injury of		
	on c rading rt. Aft			1 X Natural 5 Pending	(Month, Day,	Year)		1 Yes 2 N				
	Division of Vital Records, tal or treding Physician: The law require rs after death.	tilled iff by the tunielal director, page	Certification:	2 Accident Investig	pation 28e Place of Ir	njury - At hom	e, farm, street, facto	ry, office building, etc.			Number or Ru	ral Route Number, City
1.	Divi			4 Homicide determine					or lov	vn, State)		
( V	So H	SI 2	<b>-</b> 1	29a. Certifier 1 Cartifulna Phys	inian. To the best of m		donth accurred at t	he time date and place	and due to the	cause(s) and m	anner ac stat	ad

Registrar

DHMH 17 Rev 1/2001

OCME 2006

best

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 9, 2008

ture and title of certifier

Laron Locke MD.

State 31. Date filed (Month Pay Year) 2008

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

7 2008 3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EUGENE 14 6:10 SILVERMAN 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goal Samaritan Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 158-14-2530 80 Director 02/27/1928 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8121 MCDONOGH ROAD 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No WHITE Be Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) **ATTORNEY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY SILVERMAN JENNIE UNOBTAINABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RUTH SILVERMAN / WIFE 8121 MCDONOGH ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 04/17/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to or as a consequence of): day /Medical Examiner eumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit LUNG Can Ces Due to (or 6s a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by tamponade 1 | Yes 2 | No 3 | Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 1☐ Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KAZORY

0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Good Samaritan Hospital, 5601 Loch Raven Blud 32. Registrar's Signature

Baltimore MD

			State of Maryland / Depart FH G878 4/18/08 Hertifl	ment of H	ealth and M	lental Hygie	ene 2008	1267
F	Div.		1. Decedent's Name (First, Middle, Last)	icate of L	Jean	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		AlvertA IBROWER			APR.	5 2008	11.03PM
	Examir	ier	4a. Facility Name (If not institution, give street and number)  4b. W. RehAb. Center.	BAL V	Location of Death		4c. County of Death	
. 1	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $\frac{11}{2}$ $\frac{15-60-2413}{1}$ $\frac{11}{2}$ $1$	f Under 1 Year fonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You	9. Birth	place (State or Foreigr Intry) Unk
	ryland how at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati					10d. Inside City Limits
	the Ma 28a-f s	Director	MA. BALTO	10f. Zip Code		100	. Citizen of What Cou	1 Yes 2 No
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	th with 23a or 1st be		PAILMAIL Rd.	101. Zip 00de		1.09	4.5	A
	ours after dea ral", or items Examiner m	by Funeral	1 Never Married 2 Married 1 Yes 2 No	s Decedent of Hi es, specify Cuba Yes 2 No	spanic Origin? (Spon, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	etc.
	I within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade completed) (Give kind	t's Usual Occupa d of work done o NOT use retired,	luring most of work	ing	b. Kind of Business/li	ndustry
and	I be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	iden Surname)	
Maryi	should and Me s mark umatic	은	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing A	Address (Street a	and Number or Run	al Route Number, C	City or Town, State, Zi	p Code)
	s 1 and 2 f Health tem 27 i		NURSING HOME 460  20a. Method of Disposition 20b. Place of Disposition		11 MA	11 Rd -	BALTO. c. Location - City or T	Md 2121
Baltimore,	e = 1 €		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ory or other place	efery 4	18.08 1	Dundale	k md
Balt	permit. Par Departmen Important: any injury once.		21. Signature of Funeral Service Licensee 22. No.	ame and Address	EASTE	SV. FORNAVE.	BALTO.	Home
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	)[موع	with ,	1663C	250	
0.	Examiner	er	Sequentially list conditions, frame, leading to immediate b.					
/	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.					
8/00,	certificate be executed Iding physician and Ise as the burial-transit	dical Ex	Due to (or as a consequence of):					
0	ertificat ling phy e <b>a</b> s the	Medi	IF FEMALE:					
.O. BOX	the death y the atter ched for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pt pregnancy 1 Live birth 2 Fetal death 3 Ect	topic pregnancy ther (specify)			23d. Date of deliv Month	ery Day Year
ecords, r	w requires that the de sbeen signed by the s should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause give	en in Part I.	23e. Did tobac	cco use contribute to 2 ☐ No 3 ☐ Pro	
Ľ	The law ate has b page 2 sh	Completed				24a. Was an autopsy performe 1  Yes 2	prior to co	opsy findings available ompletion of cause of
N Kal	ysiciar is certif director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient (	3 DOA Othe	r A	n <i>(Check only one)</i> me 5□ Residenc	e 6 □Other (Spec	
on or	ing Ph After thi	on: T	27. Manner of Lath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how		
DIVISIO	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, building, etc. (Specify)		/es 2□No	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	e Hospit 124 hours e Funera letely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death oc 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the itm tigation, in my or	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
,	To th withir To th сотр	Me	29b. Signature and title of certifier  MD	29c. License	1405	4	Date signed (Month)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	J-Eu7	ewst.	Balti	vone MI	2/201
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 8 2008  32. Registrar's Signature	e e				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

46.	
Division or Vital Records, P.O. Box 68760,	. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after cleath
Division	Hospital or Attending 24 hours after death

		State of Mary	land / Depa		of H	ealth a		ental Hygi	_	nne.	12	c 70	
Dhusisi		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Vear  3. Time of										Death	
Physicia /Medic		Wanda N. T	1	APRIL					8 2008 8:15 pm				
Examin	er	4a. Facility Name (If not institution, give street and number)  Doctors Community Hospital		rown, or nham	Location of	f Death			ty of Death	eorge	e l		
Funeral			yrs. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	Prince Georges  f Birth (, Day, Year)  9. Birthplace (State or Foreign Country)				
Director		579 64 3252 1 M 2 F 60 Yrs. Months Days Hours Min. 02							Month, Day, Year) 02/01/1948 Rhode Island				
land w t		Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or Lo	cation						100	d. Inside Cit	y Limits	
Mary t-f sho	tor	Maryland Anne Arundel	Pasaden	.a							1 ☐ Yes	2 📉 No	
th the or 28% e noti	Director	10e. Street and Number	10f. Zip	Code			109	g. Citizen o	f What Countr	y?			
ath w s 23a nust b		317 Cool Breeze Court		211					5.A.				
ter de items iner m	Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Yes  2 □ Norried	in U.S. 13.	Was Deced If Yes, spec	ent of His ify Cuba	spanic Orig n, Mexican,	jin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
urs af af, or Exam	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2	<b>⊠</b> No	Specify:			Spec	Specify: White			
72 hc 'natul dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usua kind of wor DO NOT us	Occupa	ition uring most	of workin	g   10	6b. Kind of	Business/Indu	ıstry		
within ene. than '	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 12th	I	oo norus e Make		)			Owi	n Home			
i filed I Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last)	110			18. Mother	r's Name	(First, Middle, Ma			_		
wuld be Menta arked a	To B	Stanislaus Noga				Ca	aroly	n Kimble	9				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Meghan Tice / Daughter		ng Address 5 Jeri				Route Number, Bowie	City or Tow e, Mai	n, State, Zip ( ryland	<sup>Code)</sup> 20715		
es 1 a of Hea fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cre	sition (Nam	e of her place	9)	Di	ate 20	Oc. Location	- City or Tow	n, State		
t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify)	Bayview (					/2008 1				nd	
permil Depar Impor any in		21. Signal of Furtheral Service Monthsee	e 40	2. Name and 001 Ri	tchi	le Hig	ghway	nce Funer Baltin	nore,			225	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											
Physician /Medical		disease or condition resulting in death) a. Lesonabry Failure											
Examiner		Due to (or as a consequent e of):											
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nacquenes of):	LIEV	70104	0,10							
ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	testina	LE	slee	d							
icate be executed physician and s the burial-transit	cal E	Due to (or as a co	nsequence or):										
ifficate g phys		d. Seas									_		
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pro ⊒ Other <i>(sp</i> o						Date of delivery Month E	,	'ear	
res that igned b be deta	by Pr	Part II. Other significant conditions contributing to death but no			•			23e. Did toba	cco use co	ntribute to the	cause of de	eath?	
w require	ted k	End Stage Metastati	E Live	C	ance	? _		1 □ Yes	2 □ No	3 ☐ Proba	bly 4 X	Inknown	
The law rate has be page 2 sh	Completed							24a. Was an autopsy perform 1∐ Yes 2		o. Were autops prior to com death? 1 □ Yes 2	sy findings a pletion of ca !  \[ \] No	vailable use of	
ician: Th certificate rector, pag	Be C	25. Was case referred to medical			,	26. Place	of Death	(Check only one)					
hysic this ce al dire	To 1	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)											
ding F	ion:	27. Manner of Death 28a. Date of Injury  Natural 5 ☐ Pending (Month, Day Ye	ar) 28b. Time o	f   28	Bc. Injury Work			8d. Describe how	injury occ	urred		Foreign and virinits 2 1 No	
or Attendate death	Certification:	2 Accident investigation   M   1 Yes 2 No   3 Suicide 4 Homicide   See Place of injury - At home, farm, street, factory, office building, etc. (Specify)   286. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   287. Location (Street and Number or Rural Route Number or Rural							ber,				
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of manner stated	y knowledge, deat amination and/or in	h occurred a vestigation,	at the tim	ne, date and pinion, deat	d place, a	and due to the cau ed at the time, dat	use(s) and te and plac	manner as sta e, and due to t	ted. the cause(s	)	
To th withir To th comp	Me	29b. Signature and title of certifier		29c	License	number		290	d. Date sign	ned (Month, D	ay, Year)		
ì		Meather of Cas, 40		M	DD6	0113	1	A	pril,	08,3	2008		
Q		30. Name and address of person who completed cause of death  Heather H Davis, M.C.	C. 11	Print)	od	livi	2_ 2	vad, La	بماحداد،	. 410	2.075	10	
Sta	te	31. Date filed (Month, Day, Year) 32. Restrar's			-	wa		ma, m	VIV FILV	1/210	2016	2	
Registr	ar	APR 1 8 2008	J. J. F	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
A THUD THE #9, per FH, 68/8, 4/18/08, WS
State of Maryland / Department of Health and Mental Hygiene

Walter Golert Van Antwerp  Walter Golert Van Antwerp  Walter Golert Van Antwerp  Walter Golert Van Antwerp  Loral Land New of the Anthony year was and namedy			1 - For State Registrar	Otate of Ivia	-	•	ate of Dea			Reg. No.	08	1267	
Activation   The Acti	Physici	an			rp				Month	Day	Year		
Second Second States   Control of the Control of		cal			- 6	4b. C	city, Town, or Locati	on of Death	APRIL			1,301	
Turset Direction 17 - 16-54 s 1 5 ser	LAMITIM	ici	LORIEN - BE	LAIR		Ве	1 Air			# 1	ARFO	RD	
Maryland Harford Co.    Total State   Total			5. Social Security Number 6. Se	x 7. Age	(In yrs. last birti	Mont			8. Date of Bird (Month, Da Aug.	16,19	9. Birthp Coun 325 - IX	place (State or Fore htry) Indiana	
23. Part. Entire the design, or complications that caused the death. Do not elerit the mode of yong, usual mode of virging under or repriatory arrest.  Approximate the mode of yong, usual mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest, and the mode of yong, usual production or respiratory arrest, and the production of	pug *				10c City Town	or Location							
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	e Maryi≼ a-f eho	ctor		rd Co.									
23. Part. Entire the design, or complications that caused the death. Do not elerit the mode of yong, usual mode of virging under or repriatory arrest.  Approximate the mode of yong, usual mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest, and the mode of yong, usual production or respiratory arrest, and the production of	h with th	al Dire		ive		101.						-	
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	r deat	Iner	11, Marital Status	Armed Forces?		13. Was De	ecedent of Hispanic specify Cuban, Mex	Origin? (Spe	cify Yes or No Rican, etc.)	14. F			
23. Part. Either the designs, or complications that caused the death. Do not elent the mode of ying, usual or expiratory arrest.  Approximate in the mode of ying, usual or expiratory.  In the sat 12 months?  Approximate in the mode of ying, usual o	036 ours afte rai', or it	by		1√TYes 2 □ N	0								
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	72 h	lete	15. Decedent's Edu (Specify only highest grad	cation le <i>completed)</i>	16a.	Decedent's l	Isual Occupation work done during r	on 16b. Kind of Business/Industry					
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	withir then the	dmo			40r 5+)								
23. Part. Entire the design, or complications that caused the death. Do not elerit the mode of yong, usual mode of virging under or repriatory arrest.  Approximate the mode of yong, usual mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest.  Approximate the mode of yong, usual mode of yong, usual production or respiratory arrest, and the mode of yong, usual production or respiratory arrest, and the production of	other			<u> </u>		lysici s	18. M			Maiden Sun	 name)		
23. Part. Either the design, or complications that caused the death. Do not element amount of styring, uscalation or reprinting a material plant mondative (auser (Final death) (Introduction Causer (Final death)). Do not leave the mode of styring, uscalation or reprinting a material plant mondative (auser (Final death)). The part (Introduction Causer (Final death)). The part (Introduction	rian uld be Menta riked	O B	Jesse Van Antwe	rp			Lil	lian Far	mer				
23. Part. Either the design, or complications that caused the death. Do not element amount of styring, uscalation or reprinting a material plant mondative (auser (Final death) (Introduction Causer (Final death)). Do not leave the mode of styring, uscalation or reprinting a material plant mondative (auser (Final death)). The part (Introduction Causer (Final death)). The part (Introduction	lary	9	19a. Informant's Name/Relationship (T)	rpe, Print)									
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	and and m 27 m 27 her tr			werp	- 10								
23. Part. Either the design, or complications that caused the death. Do not element amount of styring, uscalation or reprinting a material plant mondative (auser (Final death) (Introduction Causer (Final death)). Do not leave the mode of styring, uscalation or reprinting a material plant mondative (auser (Final death)). The part (Introduction Causer (Final death)). The part (Introduction	imore Pages 1 nent of H ant: if ite		1 ☐ Burial 2 ② Cremation 3 ☐ F	Removal from State	Evans	runer a	or other place)  1 Chapel						
23. Part. Either the design, or complications that caused the death. Do not elents the mode of yong, usual conductor respiratory arrest.  Approximate the mode of complication of the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Approximate the mode of yong, usual conductor or spiratory arrest.  Due to (or as a consequence of):  Due to (or as a consequence of):  Casa (Dease or influence or i	Saft ermit. eparti nporti		21. Signature of Funeral Service Licens	ee					1 & Cheme	tion	Servi	ces - Pel	
Prysician Medical Examiner    Provided   Pro	m anz.a		Jan Sali Estate of To	m	the death. Do o	3 Nev	woort Driv	ze. Fa	rest Hill	. Mar	yland	21.050	
Medical Examiner  Medical Examiner  Medical Examiner  Joseph Sample State Condition of Seasy Leading to Immediate a state of Condition Seasy Leading to Immediate a state of Seasy Leading Immediate and Immediate a state of Seasy Leading Immediate and Immediate and Immediate a state of Seasy Leading Immediate and I			Immediate Course (Final										
The state of the s			disease or condition resulting in death) a. 13 KM/N   UMO K,   MAZ   GNAN										
Due to (or as a consequence of):    The conting of death   Last   Conting of the		ş											
Due to (or as a consequence of):    The conting of death   Last   Conting of the	Control of the Contro	ner	if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):										
State   Part	Scute of transi	aml	that initiated events						_				
SULPHANOWN  9. I Unknown  9. I	60, be exe		resulting in death) Last	Due to (or as a	of):								
SULDINGOWN  9. CLINKNOWN  9. C	587 S87 Sicate	odlo	d.										
SULPHANOWN  9. I Unknown  9. I	OX OX onding use a use a	n/Me								23d.	Date of delive	ary	
A grant of the control of the cause of death?    A grant   A grant	" B	icla	in the past 12 months?	4☐ Pregnant at time of death 5☐ Other (specify)						Month Day Ye			
Selection of the significant continuous cont	O	phys											
25. Was case referred to medical examiner?  1   Yes   2  No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Cther   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28a. Date of Injury   28b. Time of Injury   28b. T	S, Is the righed be de	by	and the second		_	•	-	art i.					
25. Was case referred to medical examiner?  1   Yes   2  No	ord ord requi	eted			441216187	1ENS1	ca,						
25. Was case referred to medical examiner?  1	Rec elaw has t	mple	URINARY RETE	ENTION					auto	Vas an 24b. Were autopsy findings avai utopsy prior to completion of cause death?			
29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  29b. Signature and title or certifer  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and a rr. s of person o completed cause of death (Item 23a) (Type, Print)  Suresh Phanjani MD. 6225 unionaly Expensive Phanjani MD. 6225			05.116						1 ☐ Yes	2 No	1 🗆 Yes	2 No	
29a. Certifier (Check only one) 29b. Signature and title or certifer  29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, Editory, office and Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (State Registrar)  3 (State Registrar)  3 (State Registrar)  3 (State Registrar)  4 (State Registrar)  4 (State Registrar)  4 (State Registrar)  5 (State Registra	Vit Vit sicial sicial	0	examiner?	Hospital:	4 00 500		I a .		11		01 10 1	.,	
29a. Certifier (Check only one) 29b. Signature and title or certifer  29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, Editory, office and Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)  3 (State Registrar)  3 (State Registrar)  3 (State Registrar)  3 (State Registrar)  4 (State Registrar)  4 (State Registrar)  4 (State Registrar)  5 (State Registra	Of Of Physical distribution			_			DUA 4					y)	
30. Name and a rr s of person o completed cause of death (Item 23a) (Type, Print)  SURESH DHANJANI MD, 622 S. UNION AVE, HAVRE DE GRACE MD 21078  State Registrar  31. Date filled (Month, Day, Year)  32. Registrar's Signature  APR 1 8 2008	nding nth.	atlor		(Month, Day	Year) ir			2 □No					
30. Name and a rr s of person o completed cause of death (Item 23a) (Type, Print)  SURESH DHANJANI MD, 622 S. UNION AVE, HAVRE DE GRACE MD 21078  State Registrar  31. Date filled (Month, Day, Year)  32. Registrar's Signature  APR 1 8 2008	Divis lor Atter after des Director	ertifica	determined	28e. Place of Infu building, etc	ry - At home, far (Specify)	m, street, fac	ctory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Rura	al Route Number,	
30. Name and a rr s of person o completed cause of death (Item 23a) (Type, Print)  SURESH DHANJANI MD, 622 S. UNION AVE, HAVRE DE GRACE MD 21078  State Registrar  31. Date filled (Month, Day, Year)  32. Registrar's Signature  APR 1 8 2008	Hospita 24 hours Funeral		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								tated. o the cause(s)		
30. Name and a rr s of person o completed cause of death (Item 23a) (Type, Print)  SURESH DHANJANI MD, 622 S. UNION AVE, HAVRE DE GRACE MD 21078  State Registrar  31. Date filled (Month, Day, Year)  32. Registrar's Signature  APR 1 8 2008	To the vithin To the	Me	29b. Signature and title of certifier	4			29c. License numb	oer		29d. Date sig	gned (Month,	Day, Year)	
30. Name and a rr s of person o completed cause of death (Item 23a) (Type, Print)  SURESH PHANJANI MO. 622 S. UNION AVE, HAVRE BEGRACE MO 21078  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 1 8 2008			> Maller	du M	0		0453	44		nuli	ulani	20	
SURESH PHANJANI MO, 622 S. ONION AVE, HAVRE BE GRACE MO 21078  State Registrar  APR 1 8 2008	10+1												
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature			SURESH PHANJA	WILMO,	6225.	0210	NAVE, F	HAVRE	DE GRA	CE 12	10 210	78	
PHANTA POLYMONIA			31. Date filed (Month, Day, Year)	32 Registra	r's Signatura	A RO			,	7			
LICINATE LA PRINCIPATION DE LA CONTRACTION DEL CONTRACTION DE LA C	DHMH 17 Rev 1/2	-	APR 1 8 2008	E College	10° A								

DHMH 17 Rev 1/2001

Examiner Division or Vital Records, P.O. Box 68760, After this within 24 hours at To the Funeral C

death with the Maryland

Maryland

205 Baltimore.

> 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

29b. Signature and title of certifier

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

RES - 000

12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

MD Manish 31. Date filed (Manh Ray Y8r) 2008 Begistrar's Sign

MO

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Christina Lynn Williams 4:15 PM 04/10/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2618 Tulip Avenue Baltimore Lansdowne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/09/1965 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2/ □ F Director 212-94-4748 42 Baltimore, MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ex-miner must be notified at 1 ☐ Yes 2 No MD Baltimore Lansdowne Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 2618 Tulip Avenue United States Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2X No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail/Pet Store Assistant Manager Retail 12 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Charles Charping Mary McGinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Christina Charping (Daughter) 1701 Letitia Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
arry injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 04/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Market. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxia **Physician** hanging 6 resulting in death) /Medical Die to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2★ No 24a. Was an has e 2 autopsy performed? 1☐ Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 4:15 P 1 
Natural 5 Pending investigation suicide By hanging April 10 2008 4:15 P M 1 = 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 X No 2 Accident 6 ☐ Could not be 3€ Suicide 4 ☐ Homicide 28f. Location (Street and Number of Bural Houte Number, City or Town, State) 2 ( ) 8 [ ] PAUC Landsdown, Md 21227 determined home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of leath (Item 23a) (Type, Print) H:11 CT. Lutherville Md Trimb MD 6

State Registrar 31. Date filed (Month, Day,

1 8 2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

82. Registrar's Signature

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Registrar

Michae 31. Date filed (Month, Day, Year) Registrar's Signature APR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only

29b. Signature and title of cortifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15 Donald Leroy Wilkins, Sr. 2008 April 7:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Solutions Baltimore Essex 8. Date of Birth (Month, Day, Year) 06/13/1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min 83 Maryland Director 216 16 3815 Usual Residence of Decedent a or 28a-f show the notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with rent of Healith and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or into yor other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be not U.S.A. 21227 2013 Smith Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No WW II If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University of Balto. Maintenance Mechanic 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Wilkins Ida Thompson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21227 2013 Smith Avenue Rose Suter / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 04/18/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** preum on c 2 days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed sician and burial-trans Box 68760, ☆ that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Į0 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2/2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate pertensi 1∐ Yes Division or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

24 hours after death.

e Funeral Director: After thi letely filled in by the funeral of the Hospital or Attending within 24 hor To the Fune completely fi

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and addres

29b. Signature and title of certifier

1124 Mace Die, Baltmore, MD 2/221 OR FUHN LOH 32 Registrar's Signature

f person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

H35593

29d. Date signed (Month, Day, Year)

ひひき

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:45 AM WERDEBAUGH 2008 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7508 Carroll Avenue Baltimore Co. Dundalk Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 🙊 ⋤ F 212-34-4843 Director May 27,1931 Maryland 76 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 🎗 🖾 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7508 Carroll Avenue United States 21222 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2√2 No Specify: White þ 3 ⊠ Widowed 4 □ Divorced Year or Dates: Completed Medicai 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) event, the Own Home Homemaker \_Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lijury or other traumatic event once. Be Richard A. Lewis Icey Grace Spiker ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 7508 Carroll Ave. Lisa Goolsby (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ♥ Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 4/18/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TACHYMERHYTHMIA /Medical Due to (or as a consequence of) Examiner THEUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a linknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 2 **7** No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ဥ ☐Other (Specify) After this 27 occurred

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

The Hospital or A... 94 hours after death.

Certification:

examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 □ D0	OA Other: 4 Nursing	Home 5 Residence 6
. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury

investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

29b. Signature and title of certifier

М 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

A Maria

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29c. License number D62032 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

2008

APR 18

BAYVIEW CIRCLE 505 HOPKINS TAYASHI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

DHMH 17 Rev 1/2001

within 24 hours a

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:15 P M 13, 2008 RUTH APRIL WATERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Dav. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 04/19/1921 Hours 1 □ M 2 💢 F 86 Director 215-18-7185 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State show r 28a-f show notified at 1 ☐ Yes 2 No Director HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be r 21014 USA 110 WEST HEATHER ROAD by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygene.
The marked other than "natural", or Items 23s wit: If item 27 is marked other than "natural", or Items 23s ury or other traumatic event, the Medical Examiner must. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEAH MCKENNA SOLOMON RAITZYK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 WEST HEATHER ROAD, BEL AIR. MICHAEL FILLING / SON 20b. Place of Disposition (Name of cemetery crematory or other place)
VETERANS CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/17/2008 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) TO THE Due to (or as a consequence of): au here /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed 2 No 2 No 1 ☐ Yes or Attending Physician: funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DAVID DUNN

31. Date filed (Month, Day, Year)

APR 1 8 2008

BEL AIR, MD.

21014

615 W. MACPHAIL ROAD

32 Registrar's Signature

			For State Registrar	State of Ma	ryland /			t of H			ental H	_	ne <sub>No.</sub> 20	08	12	686
~	-		Decedent's Name (First, Middle, Last)								2. Date of	Death		Vaar	3. Time of	
	Physici /Medic		CATHERINE WATSON								Month		Day 912	Year 2008	9 20	m
þ	Examin	1000	4a. Facility Name (If not institution, give st	reet and number)			4b. City,	Town, or	Location	of Death			4c. County	of Death		-
			NORTHWEST REHAB CE	NTER				LTIMO								
jy.	Funeral		Social Security Number     6. Sex	7. Age VI 2 🛣 F	(In yrs. last		If Unde Months	r 1 Year Days	If Under Hours	Min.	<ol><li>Date of (Month,</li></ol>	Day, Ye		9. Birthpla Count		r Foreign
	Director		243-22-2294	VI ZIZIT	85	Yrs.				]	NOV.	28,	1922		NC	
7	<b>M</b>		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation							10	d. Inside Cit	y Limits
1	sho	or													1 ⊠Yes	2□No
4	28a-	Director	MD 10e. Street and Number		BALTI	LMORE	10f. Zij	Code				10g.	Citizen of V	Vhat Count	ry?	
+	Sa or t be r												USA			
1	ns 23 mus	era	1122 BONAPARTE AVE	2. Was Decedent E	ver in U.S.	13. V		218 dent of Hi	spanic Or	igin? (Spec	cify Yes or Rican, etc.)		14. Race	e - America		
	med within 7.5 mouts ariet oeant with the maryand Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 □ N	o						Rican, etc.)			k, White, e		
15-UU36	al", o	by	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		'	☐Yes	21 <b>X</b> 1No	Specify:	:			Specify	BLA	_N	
	natur ical	ted	15. Decedent's Education (Specify only highest grade	ation	1	6a. Deced	ent's Usu	al Occupa	ation Jurina mos	st of workin	าต	168	b. Kind of Bu	siness/Ind	ustry	
7	an "l	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	OO NOT L	se retired,	)	st of workin	.3					
7	ygier ygier ner th	Completed	10TH			CLE	RK		10 11-11-		/Final 1414	-11 - 44-1	DELIV			
		Be	17. Father's Name (First, Middle, Last)									aie, Mai	iden Surnam	ie)		
<b>&gt;</b>		2	ARCHIE McDUFFIE							RGIA						
Mar	raum		19a. Informant's Name/Relationship (Type		'		•	,					ity or Town,			
	s I and 2 should f Health and Mer frem 27 is marke other traumatic		VALERIE DERRICK/NI  20a. Method of Disposition	ECE	20h Place	112 e of Dispos			RIE A		BAL'I'J		E, MD c. Location -	212'		
Ö	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cem	etery, cren	natory or	other plac	´ ;					•		
	rtmer rtant: njury	74	4 □ Donation 5 □ Other (Specify)  21. Signature of Soneral Service License	1	/BAL	TIMOR							LTIMO			28
g	Definit. Prage Department of Important: If any injury of once.		21. Signature of Bulleral Service Licenses	Phanil	سد								S, JR.		л. нм. 21231	
			23a Part 1. Enter the disease or complic	ations that caused	the death. [	Do not ente									Approximate Interval Bet	9
			23a. Part 1. Enter the disease or complic shock, or heart failure List only one Immediate Cause (Final	cause on each lin	e.	(	1.	800	. 1111			,	,		Onset and E	Death
	hysician /Medical	. 11	disease or condition resulting in death)	Due to (or as a	CORECGUER	car	000	myo	pa	7				-	57	V5
	xaminer			CON	1 destru	ice oi).	hear	· .	14:	lune					1.7	Va
259		ē	Sequentially list conditions, if a y, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	Doe to for ea e					rapa		_					
	d d ansit	Examine	Cause (Disease or injury													
o,	an an rial-tr		resulting in death) Last	Due to (or as a	consequen	nce of):										
2/60	ine death centilicate be executed y the attending physician and ched for use as the burial-transit	dical	d.													
٥	ng ph	Med	IF FEMALE:						-		-		1			
X POX	attending p	an/l	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome p 1 ☐ Live birth	2 ☐ Fetal de	eath 3		regnancy						te of delive	,	/ear
5	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	th 5□	Other (s	pecify)				_				
Ţ	d by tetach	Physician/Me	Part II. Other significant conditions conf	ributing to death bu	it not recultin	ng in the ur	nderlying	rause dive	an in Part		23e D	id tohac	co use cont	ribute to th	e cause of d	leath?
ecords,	w requires that the or been signed by the s should be detached	by	Tatti. Ottor significant constitutions com	inbutting to dods i be		ng iir aio ai	aonymg	saudo give	2171171 0211			□ Yes	-		ably 4 □U	
Ö	nedn hould	Completed														
မို	elaw hasb je 2 sł	npldu									24a. W	ras an utopsy erfor <b>m</b> e	d2 24b.	Were autor prior to con death?	sy findings opletion of c	avallable ause of
	icate ha		_								1□ Ye	s 2	No	1 ☐ Yes	2□ No	
Vital	rnysician: The law rthis certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No He	ospital:		VO 1 - 1'		OA Othe			(Check on					
0	riny this	۲: ۲:	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injur		NOutpatien  Bb. Time of		28c. Injury Work	4 🗷 🛚 🔻				e 6 Oth		)	
0	Afte fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		k? Yes 2.⊑	No						
DIVISION	or attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of inju	ry - At home	e, farm, str	eet, facto	y, office		2	28f. Locatio	n (Stree	et and Numb	er or Rura	Route Num	ber,
$\leq$	after after I Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specity)						City or	Town, S	State)			
	youne nospiral or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ial C	29a. Certifier 1 ☐ Certifying Physic (Check only 2 ☐ Medical Examin													.)
	in 24 in 24 ihe Fu	edical	one)	and manner sta		i andorin										
ř	Vith Com	Σ	29b. Signature and title of certifier	in n			29	c. License	number	01-		29d	. Date signe	d (Month, l	Day, Year)	
)	0		710000	1, L	)				31.	805			4/	14/	of	
	7		30. Name and address of person who for		0		Print)	en.	• /	G.	+	.t.	Date signe	ROT		nd
	Sta	to	31. Date filed (Month, Day, Year)	22. Registra		206		5 4	~.	in	1 au s	inee	1 K	11	roc 1	201
14	Regist		APR 1 8 2008	Pagaras .	B	6284	300									/

08-02863	3
Millicent	Anderson

-02863		Please Type or Print in Black Inc									
licent Anderso		State of Maryland / Depar		and Mental I	Hygiene	201	18 1268				
		Registrar	fificate of Death			. <b>N</b> o.	I o Torrest Contract				
Physicia ical Examiر		1. Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 0937 hrs				
Prłai Exaiiii		MTLLICENT (NMN) ANDERSON  4a. Facility Name (if not institution, give street and number)	Ah City Tour	n, or Location of Dea	April 12, 20	4c. County of Deat					
1		321 George Street	Bel Air	i, or Location of Dec		Harford					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1	Year If Under 24h	Irs. 8. Date of Birth	(MM/DD/YYYY) g. Bi	rthplace (State or				
Director		30	**		lin.	Forei					
	ŀ	219-72-9517 1 M 2 A F	115.		Aug. 2,	1969	TRITYTAIR				
any	Ì		Town or Location				10d. Inside City Limits				
nd show	٦	Maryland Harford Edg	jewood				1 Yes 2 XNo				
faryla	Director	10e. Street and Number	10f. Zip Co		10	g. Citizen of What Cou	untry?				
the N		3919 Love Ave.	210	40		USA					
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		of Hispanic Origin? ( uban, Mexican, Pue		14. Race - Ame White, etc.	rican Indian, Black,				
death or ite	Š	1 Yes 2 X No			no recarr, etc.)						
after		Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X				White				
hours 'natu	Completed by	11 7 7 9 9 1 7	16a. Decedent's Usual Oct during most of working			16b. Kind of Business	rindustry				
36 in 72 than t	e e	Elementary/Secondary (0-12) College (1-4 or 5+)	Accountant			Accounting	7				
d with	틍	17. Father's Name (First, Middle, Last)	Accountant	18.Mother's Na	me (First, Middle, M		1				
e file tal Hy ked o	Be	Stanley Joseph Oleska		Doris	Theresa E	ranczkowsl	κi				
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med	2	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (								
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Instit: If item 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		Doris Oleska / Mother	3919 Love		rewood, Ma						
Baltimore, MC permit. Pages 1 and 2 st Department of Health an Important: If item 27 injury or other trauma	- 1		Place of Disposition (Name or rematory or other place)	of cemetery,	Date	20c. Location - City of	or Town, State				
Page:		4 Donation 5 Other Specify: Sac	cred Heart of	Jesus 4-	-18-08	Baltimore	, MD				
alti mit. spartn ports jury o	- 1	21. Signature of Funeral Service Licensee									
		21. Signature of Funeral Service Licensee  22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Road, Abingdon, Mary  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death, failure. List only one cause on each line.	Do not enter the mode of d	lying, such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxicat  Due to (or as a consequence of)					Death				
		b	):				-				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	f):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
nted d ansit	Ex	events resulting in death) Last Due to (or as a consequence or)	,.								
e executed sian and ial - transit	ical	■ MENDED AMENDED DTT 27 3	00 C ME	070 5/11/00	) mm						
60, ate be hysici	Med	#23a, PTL 27, 2  IF FEMALE: 23c. If yes, outcome of pregn	28a-f <mark>, per ME, g</mark> nancy	28/9 3/14/00	3 11	23d. Date of delive	ery				
68760, certificate be nding physici	an/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pre	gnancy	Month	Day Year				
Box 68760, e death certificate be eath certificate by the attending physician ed for use as the buria	sici	1 Yes 2 No 9 V Unknown g Unknown	ath 5 Other (Specify	"							
he tr de	Physician/Med	Part II. Other significant conditions contributing to death but not re	esulting in the underlying ca	ause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?				
ires that to signed by lbe detac	þ	Cocaine use	, ,	v	1 Yes	2 ✔ No 3 P	robabiy 4 Unknown				
rds, require been si	Completed				24a. Was a		autopsy findings available				
COC law 1 has be e 2 sh	ď				autop	med? death'					
tal Recian: The certificate ector, page		25. Was case referred to medical	26	Place of Death (Che	1 Yes	2 No 1	Yes 2 No				
of Vital Records,  g Physician: The law requir  the configurate has been s  neral director, page 2 should t	Be	examiner? Hospital: 4 Innetiont 2	ER/Outpatient 3 DO/	Other		Residence 6 V Ott	ner: Scene				
of V g Phy her th	. To	27. Manner of Death 28a. Date of Injury		c. Injury at Work?		now injury occurred					
ath.	tion	1 Natural 5 Pending (Month, Dey, Year) 2 Assistant Investigation Fnd 4/12/2008	Fnd 9:30 am	Yes 2 X No	subject t	ook medicati	on				
Division tal or Attendi 15 after death. 18 Director: //	fica	2 Accident investigation	ome, farm, street, factory, o	ffice building, etc.			Rural Route Number, City				
Division of Vital I ospital or Attending Physician: I hours after death. Mer this certifi uneral Director: After this certifi by filled in by the funeral director.	Certification:	4 Homicide determined (Specify) house			321 Geor	ge St. BE1 A	ir, MD				
<b>本 22 体 8 l</b>		29a. Certifier 1 Certifying Physician: To the best of my knowledg	ge, death occurred at the tir	me, date and place,	and due to the caus	e(s) and manner as s	ated.				
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination are and manner stated.	nd/or investigation, in my o	pinion, death occurr	ed at the time, date						
	ž	29b. Signature and title of certifier		icense number		29d. Date signed (#	Month, Day, Year)				
		Mayore The Krile		D.C.M.E.		April 13, 2008					
		30. Name and address of person who completed cause of death (Item		at Daltimana t	ID 21201						
	_	Margarita Korell MD. Assistant Medical Examina  31. Date filed (Month, Day, Year)  32. Registrar's Signatu		at, Daltimore, N	ID 2 120 1						
Si Regis	ate trar	` \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	tools								

Registrar

DX-

DHMH 17 Rev 1/2001

State

Registrar

M.A. HAMADEH

31. Date filed (Month, Day, Year)

, ELKTON, MD

BOW STREET

Registrar's Signature

106

APR 1 8 2008

			1- State of Maryland / Department	artment of Health and N	lental Hygie	2000	12689
		- 1	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Gwendolyn Lea Bartles		APRIL	5 2008	1239 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Washington County Hospital	Hagerstown		Washington	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  222-42-5577 1□ M 2☒ F 62 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yo	ear) Country	
	Director		Usual Residence of Decedent		July 5,19	945  Maryla	and
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation		10d	I. Inside City Limits
	Mary Fled a	ţ	Maryland Washington Hagerstow	'n			1 X Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	1?
	th wit	a D	11 South Walnut Street Apt.306	21740		USA	
	n 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show edical Examiner must be notitled at	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
36	, or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:		Specify: White	
ğ	hours tural"		3 ☐ Widowed 4 ☑ Divorced Year or Dates:	dent's Usual Occupation	4.0		
ς Υ	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/Indus	stry
7.	withi iene. • thar the M	E O	Elementary/Secondary (0-12) College (1-4or 5+) House	· ·		Home	
0		BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	iden Surname)	
<u>a</u>	should be filed within 7 nd Mental Hygiene. marked other than "r matic event, <u>the Med</u>	To B	William Preston McKee	Rhoda Id	della Hoft	fman	
ary	shot	-	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip C	ode)
Σ	and 2 ealth n 27 i				ourg,WV 25	5405	
o O	es 1 of He if Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of matory or other place)	Date 20	c. Location - City or Town	n, State
Ě	Pag ment ant:		4 Donation 5 Other (Specify) Green laws	n Mem. Park 04-10	-2008 Wi	Iliamsport,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Fineral Secretary 2	2. Name and Address of Facility Ost	orne Fune	eral Home,P.	Α.
_			7 light the 14	25 S.Conococheague	st. Wi	lliamsport,M	ID 21795
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	lr lr	pproximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Fibrillation			moot and boam
	/Medical Examiner		Due to (or as a consequence of):				
		<u>6</u>	Sequentially list conditions,  Due to or as a punse wence of:	Μ			
	rted Insit	i i	cause. Enter Underlying Cause (Disease or injury				
,	execting and ial-tra	Examiner	that initiated events c c Due to (or as a consequence of):				
8/pn	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burat-transit	dical	d				
Ŏ	tifical ig phy as th	ledi					
X P P	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth   2 □ Fetal death   3 □	⊒Ectopic pregnancy		23d. Date of delivery	
	ed for	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Da	ay Year
r S	at the	Phy	9 LI OUKUOMU				
Š,	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		cco use contribute to the	
Vital Record	requi	Completed	HAber Jibi gemid	<u> </u>	1 ☐ Yes	2 No 3 Probab	oly 4 Unknown
ခ် ဂ	e law	nple			24a. Was an autopsy	prior to comp	y findings available letion of cause of
<u></u>	'siclan: The law s certificate has t lirector, page 2 s	ပ်			performe 1□ Yes 2 •		□ No
	siclar certif	Be	25. Was case referred to medical examiner?  Hospital:	Othors	n (Check only one)		
Ö	Phys r this rai dii	۲:	1 ☐ Yes 2 ☐ No riospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiel  27. Manner of Death 28a. Date of Injury 28b. Time of	TIL 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how	ce 6 Other (Specify)	
0	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	Edd. Describe now	injury occurred	
IVISION	Atten deat ector	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st		28f. Location (Stree	et and Number or Rural F	Route Number,
$\leq$	al or after i Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)	
	lospita 4 hours Funera ely fille		29a. Certifier Check only (Check only (Che	th occurred at the time, date and place, expestigation, in my opinion, death occur	and due to the caus	se(s) and manner as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		. Date signed (Month, Da	
	m > m 0		► M. 1 ( w) . L ( w)	DOCS7285		4/07/2	
			30. Name and address of person who completed cause of death (Item 23a) (Type,			11 11	-
2	4.1		C. 1/ :\ :\ :\ .	alnut St. #102 1	Lager Lawn	MD 21741	0
45	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 8 2008  32. Registrar's Signature	Southwest 2	J	7, 211	
	riogisti	WIT .	THE COLUMN TO SEE THE				

DHMH 17 Rev 1/2001

		Plea  1 - State Registrar	State of Mar	yland / Dep		f Healt	h and M	lental Hy	_	12690
Physici /Medio		1. Decedent's Name (First, Middle Mary Catherin						2. Date of Dea Month April	Day Year	3. Time of Death  11:30 p.M.
Examir		4a. Facility Name (If not institution 334 Sunbrook I	,	-		vn, or Locat	ion of Death	•	4c. County of De.	ath
Funeral Director		5. Social Security Number 217–10–3323		In yrs. last birthda Yrs.	y) If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day August	9. Bi 28,1919	irthplace (State or Foreign Country) Maryland
Maryland f show ied at	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wa	ashington	Oc. City, Town or						10d. Inside City Limits 1 🖾 Yes 2 🗆 No
with the 3a or 28a- st be notif	Funeral Director	10e. Street and Number 334 Sunbrook			10f. Zip Co	de 1742			10g. Citizen of What C	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2X Marr 3 □ Widowed 4 □ Divorced	If Yes Give	er in U.S.	B. Was Deceden If Yes, specify  1 ☐ Yes 2   【		c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Arr Black, Wh Specify:	
within 72 ho ene. than "natur ne Medical.	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	nt's Education sst grade completed)  College (1-4or 5+)	(Gin	edent's Usual Covered to the kind of work of the book	ccupation lone during etired)	most of work	sing	16b. Kind of Busines	_
Idlic filed view fental Hygierked other	To Be Co	17. Father's Name (First, Middle,  James Norman	*					e (First, Middle, Belle	Maiden Surname)	
and 2 shoualth and N 27 is mail		19a. Informant's Name/Relations Glenn Barnhart		334	Sunbro	ok Lai			er, City or Town, State,	
Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of Dis cemetery, co Rest Ha			4/7	Date / 08	20c. Location - City of Hagerstown	or Town, State
permit. Departiment Import any Inj			L. Vestal			/ilson	Blvd	., Hageı	FUNERAL HON	
Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that caused the tonly one cause on each line.	ne death. Do not e	enter the mode of	f dying, suc	ch as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner	er		b. Carole Due to (or as a	consequence of):	nosis	, 12	euno	<b>~</b>	4.0	22 days
ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					•	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic preg 5 □ Other <i>(speci</i>				23d. Date of d Month	delivery Day Year
quires that quires that an signed build be det	ed by P	Part ly Other significant condition	ions contributing to death but	not resulting in the	underlying caus	e given in F	Part I.	23e. Did t		to the cause of death?  Probably 4 □Unknown
The law recate has bee	Complete	Hy seriors,	sin "			-	*	24a. Was auto perfo 1∐ Yes	an 24b. Were prior to death 220 No 1 1 1	
VII.c siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Other		th (Check only o		
nding Physith. Th. After this stuneral di	ition: To	1 Yes 2 Ho  27. Manner Death  1 Natural 5 Pendir 2 Accident investi	1 ☐ Inpatient 28a. Date of Injury (Month, Day) igation	28b. Time		Injury at Work? 1 ☐ Yes			dence 6 ☐Other (Sp how injury occurred	pecify)
safer dea	Certification:	3 ☐ Suicide 6 ☐ Could determ		y - At home, farm, (Specify)	street, factory, o	ffice		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,
he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier 1	ing Physician: To the best of I Examiner: On the basis of e and manner state	examination and/or	eath occurred at investigation, in	the time, da my opinior	ate and place n, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. due to the cause(s)
To t Withi To tl	Ž	29b. Signature and title of certifie		O		icense num D2 78			29d. Date signed (Mo	onth, Day, Year)

WH-5

FAADUSCO 31. Date filed (Month, Day, Year) APR 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FIADCISCO ANDRADE 3 SO HILL ST.

DHMH 17 Rev 1/2001

State Registrar AAGERSTOWN MD 21740

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of N	Marylan		artment of F rtificate of				giene, Reg. No 🎾	200	8	12691
		Decedent's Name (First, Middi	e, Last)						2. Date of De Month	ath Day	Ye	ar	3. Time of Death
Physici /Medi		Estella Ruth B	ittinger						April 2	2, 20	08		8:30 P <sup>M</sup>
Examir		4a. Facility Name (If not institution				4b. City, Town, c		of Death			County of D		
		Frostburg Vill 5. Social Security Number		Home Age (In yrs. I	last hirthday)	Frostbur If Under 1 Year		24 Hrs.	8. Date of Bir	th	legan		ace (State or Foreign
Funeral Director		215 <b>-</b> 78 <b>-</b> 0093	1 □ M 2 <b>X</b> F		96 Yrs.	Months Days	Hours	Min.	Jan. 28	y, <i>Year)</i> 3, 19		Countr	land
D		Usual Residence of Decedent										140	d Incide City Limite
arylan show d at	_	10a. State 10b. County			y, Town or Lo							10	d. Inside City Limits 1 ☐ Yes 2 X No
he Ma 28a-f	Director	MD Garre  10e. Street and Number	tt	Gra	antsvi.	10f. Zip Code				10a Citiz	en of What	l Counti	rv?
with ta or 2	흐					21536	5			-	USA		
ms 23	Funeral	53 Shawnee Lan	12. Was Decede	nt Ever in U.	S. 13. 1	Was Decedent of H		rigin? (Spec	cify Yes or No		4. Race - A		
DESILLIMOTE, INIGITY INITION A LATIONOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipty or other traumatic event, the Medical Examiner must be notifited at once.	by Fur	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	I If Yes, Give	<b>X</b> No		nr Yes, specify Cub 1 □ Yes 2 <b>1</b> 2 No			tican, etc.)		Black, V Specify:		White
2 hours atural", cal Exa	fed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	pation	et of workin	a	16b. Kin	d of Busine	ess/Ind	ustry
thin 7; e. an "n Medi	Completed	(Specify only night	est grade completed)  College (1-4c	or 5+)		kind of work done DO NOT use retire	ed)	Si di waikiii	g		^- m L	Jomo	
ed will ygien t, the	ပ္ပ	10			Home	maker	10 14-16	awa Nama	/First Middle	L	Own E	One	
d be file ontal Hy ced oth	Be	17. Father's Name (First, Middle						tha Yo	(First, Middle	, ivialderi s	Surname)		
hould d Mer marke matic	2	Clarence Beachy 19a, Informant's Name/Relations		<u> </u>	19b. Mailii	ng Address (Street				er, City or	Town, Sta	te, Zip (	Code)
Mithan ulth an 27 is rtrau		Kermit L. Bitti				hawnee La					2153		
s 1 ar		20a. Method of Disposition		20b. F		osition (Name of matory or other pla			ate		cation - City	or Tov	vn, State
Page Page nent c		1  Burial 2 □ Cremation 4 □ Donation 5 □ Other (			antsvi	lle Cemet	tery						
Dallimor permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service	Luman	)		2. Name and Address.  O. Box					Home 2153		P.A.
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	sed the deat									Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	NE		EMIL	DYSPA							Onset and Death
/Medical		resulting in death)		as a conseq	uence of):			-					W 5 ym
Examiner	L	Sequentially list conditions,	b	ENTIF								250	w 5 ym
ed sit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for	as a conseq	ua lua (1).								Ŭ
xecut and	xan	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):							+	
icate be executed physician and sthe burial-transit	dical E		d										
	ledic		- u.			1077							
death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna h 2 □ Feta		⊒Ectopic pregnanc	CV			2	23d. Date o Month		ry Day Year
be deal	sicia	in the past 12 months?		nt at time of c		Other (specify)					WORT		Day real
hat the d by the letache	Phy	9 ☐ Unknown\ Part II. Other significant condit	tions contributing to deal	th but not res	ulting in the u	ınderlying cause di	iven in Part	ı.	23e. Did	tobacco u	se contribu	ite to th	e cause of death?
wrequires that the death certifue signed by the attending should be detached for use an	d by	Tarri. Other organization and	Total Control Date of the Control						1 🗆	Yes 2[	□ No 3[	_ Proba	ably 4 Unknown
ecord law requir as been si 2 should I	Completed								24a. Was		24b. Wei	re autop	osy findings available
The la	dwo								auto perf 1 Yes	opsy ormed? 2 <b>M</b> No	dea	ith?	npletion of cause of 2□ No
	Be Co	25. Was case referred to medic	al			æ	26. Plac	ce of Death	(Check only			7 7 03	20110
<u> </u>	To B	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	III 3 DOA		Jursing Hor	ne 5□Res	idence 6	6 □Other (	Specify	)
On Or ding Phy After this funeral d		27. Manner of Death 1. ► Natural 5 □ Pend	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time o Injury	Wo			28d. Describe	how injur	y occurred		
SIO tendi eath. for: A	catio	2 Accident inves 3 Suicide 6 Could	tigation	Cinium At In			Yes 2		Of Location	(Circat on	d Mumber	or Puro	I Pauto Number
LIVISION  or Attending after death. Director: After	Certification:		mined   Zoe. Flace U	, etc. <i>(Speci</i>	ome, tarm, st fy)	reet, factory, office	,	1		own, State		or <b>H</b> urai	l Route Number,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Co		ring Physician: To the ball Examiner: On the bas	is of examina									
o the ithin 2 o the omple	Med	29b. Signature and title of certif		, stateu.		29c, Licer	nse number	r		29d. Dat	te signed (/	Month, I	Day, Year)
F ≯ F ŏ		•	Holm			020	3907	7		M	PRIL.	42	900
	_	30. Name and address of perso		of death (Iter	m 23a) (Type		, ,					<del>)</del> -	
	5	Harjit Sidhu,	M.D., 925 J	Bishop	Walsh	Rd., Cu	mberl	and,	MD 21	502			
St Regis	ate trar	31. Date filed (Month, Day, Yea	8 2008 32. <b>Be</b> g	gistrar's Sign	ature	breth							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🦳 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year .Month Physician Apri 150 M Mary Louise Chipman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Cheverly Prince Georges 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🔀 F 213-54-5879 59 Director Sept. 12, 1948 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State d other than "natural", or items 23a or 28a-f show event, the Wedcal Examinar in ust be mained at 1 X Yes 2 □ No Director Prince Georges Cheverly 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20784 USA 2713 Lake Ave. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2L No Specify 2 Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Computers Computer Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. Mary Jo DeWitt Harry G. Chipman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 72, Girdletree, MD Harry G. Chipman, Jr./Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hoyes United Meth. Cem. April 12, 2008 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. man P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** avo disease or condition resulting in death) nacc /Medical Due to (or as a consequence of): Examiner equipleation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To nours after death.

neral Director: After this
y filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 D Homicide e Funeral C

P.O. Box 68760, Division of Vital Records,

> State Registrar

within 2 To the I

29a. Certifier

29b. Signature and title of certified

evi

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

3001

32. Registrar's Signature

Medical

DHMH 17 Rev 1/200

ORIGINAL

Cheveriu

29c. License number

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

08-02573 Amy Dawson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ April 1, 2008 0645 hrs Medical Examiner Amy Dawson c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bel Pre Road & Connecticut Avenue Silver Spring Montgomery 9. Birthplace (State or If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Hours Days Director Country) 08/20/1954 577 84 2776 GA M 2 X F 53 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County Yes 2 No must be notified at once. MD Montgomery Bethesda ore, MD 21215-0036 set 1 and 2 should be filted within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10f Zin Code 10g. Citizen of What Country's 10e. Street and Number 20817 United States 7408 Nevis Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 X Never Married 2 Married Yes White Yes. Give Yea Yes 2 X No specify: Specify Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Internal Revenue Elementary/Secondary (0-12) College (1-4 or 5+) Mail Clerk Service 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marianne Atherholt Be Howard A. Dawson, Jr. marked natic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7408 Nevis Rd. Bethesda, MD 20817 Howard A. Dawson, Jr. -father If item 27 Baltimore, N permit. Pages I and Department of Healti Important: If item 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State National Crematory 4/05/2008 Falls Church, VA Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph Gawler's Sons, Inc. Ave.,NW Washington Anthony Murray Approximate Interval 23a. Part I. Enter the disease, or complications caused the death (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last rand transi Physician/Medical icate has been signed by the attending physician page 2 should be detached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death nast 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autonsy findings available prior to completion of cause of autopsy this certificate has death? performed? ✓ Yes 2 1 🗸 Yes Nο 2 No 25. Was case referred to medical 26.Place of Death (Check only one : Hospital or Attending Physician: 24 hours after death. funeral director, Be Other<sub>4</sub> Hospital: 4 Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury (Month Day,Year) Apr 1, 2008 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: Pedestrian struck by auto 0639 hrs 1 Natural Yes 2 V No Pending To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Bel Pre Road & Connecticut Avenue, Silver Spring, MD determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m O.C.M.E. April 2, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, APR 32 Registrar's Signat

DHMH 17 Rev 1/2001 **OCMF 2006** 

State

Registra

ear 3

2008

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Ivial	•		of Death		eg. No. 0	) 8 I	2694
Dhy	rcieian	1. Decedent's Name (First, Middle, L	-				2. Dete of Deal		Year 3	3. Time of Death
	sician ledical	Deretta B. Duckw	orth				April	4, 2008		1:15 AM
	miner	4a Fecility Neme (If not institution, g					r Location of Death	4c. County		
		Garrett Co. Memo	rial Hospita	al		Oakland		Garre	tt	
Fund Direc		5. Social Security Number 6.  293–20–5187  Usuel Residence of Decedent	Sex 7. Age (	(In yrs. last birthda 86 Yrs.	Months	1 Year If Under 24 Hr Days Hours Mir		, 1921	9. Birthplace Country) Maryla	e (State or Foreign and
rylend	<b>5</b> .	10a. State 10b. County	1	IOc. City, Town or	Location					Inside City Limits
₩ ₩	cto	MD Garrett		Acciden	t					1 ☐ Yes 2 🔀 No
9. th	ire i	10e. Street end Number			10f. Zip	Code	1	0g. Citizen of V	Vhat Country	?
£ € 8	<u> </u>	868 Bumble Bee R	d.		215	520		USA		
Baltimore, Maryland 21215-0036 permit. Peges 1 end 2 should be filed within 72 hours after death with the Menylend Department of Heelth end Mentel Hygiene. Important: If them 27 is marked other than "natural", or thems 23e or 28e-f show	Be Completed by Funeral Director	11. Maritel Stetus  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ev. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give	er in U,S. 1		ent of Hispanic Origin? ( fy Cuban, Mexican, Pue No Specify:	Specify Yes or No- irto Rican, etc.)		e - American ck, White, etc.	
Baltimore, Maryland 21215-0036 semit. Peges 1 end 2 should be filed within 72 hours at Pepertment of Heelth end Mentel Hygiene.	D D	15. Decedent's	Year or Dates:	160 Do	edent's Usuel	Occupation		16b. Kind of Bu	Whit	
15.	jete	(Specify only highest g	rade completed)	(Gi	ve kind of worl	k done during most of we retired)	orking	TOD. KING OF BU	SITIOSSYTTOUS	шy
± 8 € ±	Ë	Elementary/Secondary (0-12)	College (1-4or 5+)					Own H	ome	
D FE	Ü	17. Father's Neme (First, Middle, Las	rt)		Homemal		ame (First, Middle, I			
d be entel	ToB	Nelson Brenneman				Puth A	. Glotfel	<b>-</b> 57		
Shoul M	F	19a. Informant's Name/Reletionship		19b. Ma	iling Address	(Street and Number or F		-	State, Zip Cc	ode)
Magarian Mag		Arlene D. McKenz				Bee Rd., A			520	,
O - E		20a. Method of Disposition		20b. Place of Dis			-	20c. Location -		, State
mo eges ant of tr: ff h	5	1 ☑ Burial 2 ☐ Cremation 3	nemovarirom State				1			
Itir orten		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral-Service Lice				neran Cem.  Address of Fecility				
Dem Dem	500	Il Loud	Jeman	1	P.O. Bo	x 275, Gran		MD 21	omes, 536	P.A.
Physic /Medi		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nblications that caused the yone cause on each line.	e death. Do not e	enter the mode	of dying, such as cerdia	ac or respiratory arr	est,	Int	oproxi <i>m</i> ate terval Between nset and Death
Exami		Immediate Cause (Final disease or condition resulting in death)	acute co	ngestive	heart	failure			24	hours
1	ē ē			le to (or es a cons		vascular di				
pet I	ᇤ		l b			vascular di	sease		yea	irs
ords, P.O. Box 68760, requires that the death certificate be executed een signed by the ettending physicien and hand had deconded for the brind had been signed by the ettending physicien and the product of the produc	ai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or es a consequence of):							
c 687	=	resulting in death) Last	Du	e to (or as a cons	equence of):				1	
Box eath cert	Physician/		d						-	
of the dea	/sic	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying ca	use given in Part I.	23b. Did to	bacco use cor	tribute to the	e cause of death?
S, P.O es thet the igned by the	by Phy						1 🗆 Y	es 2 No	3 Probab	ly 4 <u>⊱∏</u> {Unknown
S × S S S S S S S S S S S S S S S S S S	pleted						24a. Was a perform	n autopsy ned?	24b. Were availate compless of dear	autopsy findings ble prior to letion of cause th?
I Rec	E						+CY:	e ZUNo	1 □ Y	es 2 No
Vital I	BeC	25. Was case referred to medical			. R E	26. Place of De	eath (Check only on			
of Vita Physician: this certific		examiner? 1  Yes 2 No	Hospital:	2 ER/Outpat	ent 3 DO	(Othor:	Home 5 ☐ Reside		ar (Specify)	
Division of Vital or Attending Physician: T after Geeth: Director: After this carificet The funded dispersed of the control of	atlon: 1	27. Menner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Y		of 28	c. Injury et Work? 1 Yes 2 No	28d. Describe ho			
Division o  To the Hospital or Attending Ph Within 24 hours after deeth. To the Funerel Director. After it To complate filled in but strated	edical Certification:	3 Suicide 6 Could not determined	28e. Plece of Injury building, etc. (	- At home, farm, Specify)	street, factory,	office	28f. Location (St City or Town		er or Rural Ro	oute Number,
Hospita     24 hours     Funeral	odicai (	29a. Certifier (Check only one)  1 X Certifyi G P 2 Medical Exa	hysician: To the best of miner: On the basis of ex and manner stated	amination and/or	ath occurred a investigation, i	t the time, date and place in my opinion, death occ	e, and due to the ca surred at the time, d	ause(s) and ma ate and place, a	nner as state and due to the	d. e cause(s)
Nithin To the	×	29b. Signature and title Certifier			29c. License number 29d. Date si				d (Month, Day	r, Year)
- > - (		X			_ D00	23979	(	04/08/2	800	
7		30. Neme deddress of person who	completed cause of deet	th (Item 23a) (Tyn	e. Print)					
	6	Robert A. Gorals		11 N Fou:		eet Oaklar	nd MD 2	1550		
	State	31. Dete filed (Month, Day, Year)	32 Registrer's		LLII DLI	.cet Oaktai	iu, PID Z	1990		
Rec	istrar		2008	. B. L.	books					

DHMH 16 Rev 6/95

**ORIGINAL** 

31. Date filed (Month, Day, Year)
APR 1 State Registra

Carol Allan, MD

32. Registrar's Signature

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 10, 2008

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

8 2008

10d. Inside City Limits

1 XYes 2 ☐No

10c. City, Town or Location

/Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. f show ō Baltimore, Maryland 21215-0036 Phys /Mo

**Physician** 

10a. State

10b. County

Exa

To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

Directo	Maryland   Carro	11	UIIIU	n Bridge			
י ם	10e. Street and Number		10f. Zip Co	ode	10g.	Citizen of What Cou	untry?
	1 S. Main St.	., Apt. 1		21791		U.S.	Α.
Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Deceden	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		No Specify:	nicari, etc.)	Black, White	lack
eted	15. Decedent's E (Specify only highest gra		16a. Decedent's Usual C	Occupation lone during most of worki etired)	ing   16b	. Kind of Business/I	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	custod		I .	manufactu	ring
Be C	17. Father's Name (First, Middle, Last	")		18. Mother's Name	e (First, Middle, Maid		
일	Wilbur Gre	een		E1	izabeth B	rooks	
	19a. Informant's Name/Relationship (	(Type. Print)	19b. Mailing Address (S	treet and Number or Rura	al Route Number, Cit	ty or Town, State, Z	ip Code)
	June E. Green/ wi	ife	1 S. Main S	t. Apt. 1	Union	Bridge,	MD 21791
- 11	20a. Method of Disposition	20b. F	Place of Disposition (Name cemetery, crematory or other	of [		Location - City or 1	
- 1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Themoval from State	. Joy Cemete	1	/2008 Un	iontown	MD
	21. Signature of Juneral Service Lies			ddress of Facility	/2000   011	Tontown,	שמ
. 1	* offmrine	XaiDla		address of Facility Har			
$\dashv$	23a. Part1. Enter the disease, or com	polications that equand the deat			ion Bridge	e, MD 21/	
	shock, or heart failure. List only	one cause on each line.			or respiratory arrest,		Approximate Interval Betwee Onset and Dea
	Immediate Cause (Final disease or condition	_a	5	40515			Weeks
- 1	resulting in death)	Due to (or as a conseq	uence of):				
.	Sequentially list conditions	b					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
am	that initiated events	C					
<u>й</u>	resulting in death) Last	Due to (or as a conseq	uence of):				
ca		▲d					
ed				_			
₹	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna				23d. Date of deli	very
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month	Day Yea
S	9 Unknown	9□ Unknown				1	
6	3 LI Olikilowii						
y Physician/Medical	Part II. Other significant conditions	contributing to death but not resi	ulting in the underlying caus	e given in Part I.	23e. Did tobacc	co use contribute to	the cause of deat
5		contributing to death but not res	ulting in the underlying caus	e given in Part I.	23e. Did tobacc		
5		contributing to death but not resi	ulting in the underlying caus	e given in Part I.	1 ☐ Yes	2 No 3 Pro	obably 4 Unk
5		contributing to death but not resi	ulting in the underlying caus	e given in Part I.	1 ☐ Yes	2 No 3 Pro	obably 4 Unk
5		contributing to death but not resi	ulting in the underlying caus	e given in Part I.	1 ☐ Yes 24a. Was an	2 No 3 Pro	obably 4 Unk
Completed by	Part II. Other significant conditions of			26. Place of Death	1 Tyes  24a. Was an autopsy performed 1 Yes 2 1	24b. Were aur prior to c death?	obably 4 □Unk topsy findings ava ompletion of caus 2 □ No
Completed by	Part II. Other significant conditions			26. Place of Death	1 Tyes  24a. Was an autopsy performed 1 Yes 2 1	24b. Were aur prior to c death?	obably 4 □Unk topsy findings ava ompletion of caus 2 □ No
To Be Completed by	Part II. Other significant conditions of the significant condition	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3□ DOA 28b. Time of 28c.	26. Place of Death Other: 4 □ Nursing Ho	1 Tyes  24a. Was an autopsy performed 1 Yes 2 1	2 No 3 Pro  24b. Were autiprior to codeath? No 1 Yes	obably 4 □Unk topsy findings ava ompletion of caus 2 □ No
To Be Completed by	Part II. Other significant conditions of the con	Hospital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatient 3 DOA	26. Place of Death Other: 4 □ Nursing Ho	1  Yes  24a. Was an autopsy performed 1 Yes 22 h (Check only one) me 5 Residence	2 No 3 Pro  24b. Were autiprior to codeath? No 1 Yes	obably 4 □Unk topsy findings ava ompletion of caus 2 □ No
To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Many of of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury M ome, farm, street, factory, o	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} 2 \) \( \text{No} \)	24a. Was an autopsy performed 1 Yes 2 1 h (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Street	24b. Were autrifier to codeath? No 1 Yes  6 Other (Special Conjury occurred	obably 4 □Unk topsy findings ava ompletion of caus 2 □ No
To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1   Inpatient 2    28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury M ome, farm, street, factory, o	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} 2 \) \( \text{No} \)	24a. Was an autopsy performed 1 Yes 2 An (Check only one)  me 5 Residence 28d. Describe how in	24b. Were autrifier to codeath? No 1 Yes  6 Other (Special Conjury occurred	obably 4 □Unki topsy findings ava ompletion of cause 2 □ No
Certification: To Be Completed by	Part II. Other significant conditions of the significant condition	Hospital: 1 Inpatient 2 Inpatient 2 Sa. Date of Injury (Month, Day Year)  28a. Place of injury - At he building, etc. (Specification)	ER/Outpatient 3 DOA  28b. Time of 28c. Injury M  ome, farm, street, factory, o	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} 2 \) \( \text{No} \) Iffice	24a. Was an autopsy performed 1 Yes 2 An (Check only one) The Signature Residence 28d. Describe how in 28f. Location (Street City or Town, Street City and due to the cause	2 No 3 Pro 24b. Were autiprior to cideath? No 1 Yes  e 6 Other (Special Property occurred)  and Number or Rutate)	topsy findings ava ompletion of caus  2 No  ral Route Number
Certification: To Be Completed by	Part II. Other significant conditions of the significant condition	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)   1   28e. Place of injury - At he building, etc. (Specification)	ER/Outpatient 3 DOA  28b. Time of 28c. Injury M  ome, farm, street, factory, o	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} 2 \) \( \text{No} \) Iffice	24a. Was an autopsy performed 1 Yes 2 An (Check only one) The Signature Residence 28d. Describe how in 28f. Location (Street City or Town, Street City and due to the cause	2 No 3 Pro 24b. Were autiprior to cideath? No 1 Yes  e 6 Other (Special Property occurred)  and Number or Rutate)	topsy findings ava ompletion of cause 2 No
To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA  28b. Time of 28c. Injury M  ome, farm, street, factory, o  wledge, death occurred at tition and/or investigation, in	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} 2 \) \( \text{No} \) Iffice	24a. Was an autopsy performed 1 Yes 2 And the time, date	2 No 3 Pro 24b. Were autiprior to cideath? No 1 Yes  e 6 Other (Special Property occurred)  and Number or Rutate)	topsy findings ava ompletion of caus 2 No  No  ral Route Number stated. to the cause(s)
Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Alatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not b determined  29a. Certifier (Check only one) 1 Certifying Procession of the could not be determined 1 Certifying Procession one)	Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA  28b. Time of linjury M  ome, farm, street, factory, o  wledge, death occurred at tition and/or investigation, in	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} \) 2 \( \text{No} \) Iffice the time, date and place, my opinion, death occurrence.	24a. Was an autopsy performed 1 Yes 2 And the time, date	24b. Were autrior to code death? No 1 Yes  24b. Were autrior to code death? No 1 Yes  26 6 Other (Special Company) occurred  27 and Number or Rutate)  28 and manner as and place, and due	topsy findings ava ompletion of caus 2 No  No  ral Route Number stated. to the cause(s)
Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 1 Certifying Professional Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA  28b. Time of linjury M  ome, farm, street, factory, o  wledge, death occurred at tition and/or investigation, in	26. Place of Death Other: 4 \( \t \) Nursing Ho Injury at Work? 1 \( \t \) Yes 2 \( \t \) No  ffice  the time, date and place, my opinion, death occurr cense number	24a. Was an autopsy performed 1 Yes 2 And the time, date	2 No 3 Pro 24b. Were autiprior to cideath? No 1 Yes  6 Other (Special Properties) and Number or Rulate)  e(s) and manner as and place, and due  Date signed (Month)	topsy findings ava ompletion of caus 2 No
Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 1 Certifying Professional Certifier  29b. Signature and title of certifier  30. Name and address of person who	Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA  28b. Time of linjury M  ome, farm, street, factory, o  wledge, death occurred at tition and/or investigation, in	26. Place of Death Other: 4 \( \text{Nursing Ho} \) Injury at Work? 1 \( \text{Yes} \) 2 \( \text{No} \) Iffice  the time, date and place, my opinion, death occurs occurs number	24a. Was an autopsy performed 1 Yes 2 1 Am (Check only one) one 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street at the time, date	24b. Were autrior to cideath? No 1 Yes  24b. Were autrior to cideath? No 1 Yes  26 Other (Special Conjury occurred)  27 and Number or Rulate)  28 and manner as and place, and due  Date signed (Month)	topsy findings ava ompletion of caus 2 No
Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 1 Certifying Professional Check only one)  29b. Signature and title of certifier	Hospital: 1   Inpatient 2    28a. Date of Injury (Month, Day Year)  28e. Place of injury - At he building, etc. (Specifinysician: To the best of my knominer: On the basis of examina and manner stated.  Completed cause of death (Item 2 5 5 5 4 2 W from the basis of examina and manner stated.	ER/Outpatient 3 DOA  28b. Time of linjury M  ome, farm, street, factory, o  wledge, death occurred at tition and/or investigation, in	26. Place of Death Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No Iffice the time, date and place, my opinion, death occurr cense number	24a. Was an autopsy performed 1 Yes 2 And the time, date	2 No 3 Pro 24b. Were autiprior to cideath? No 1 Yes  6 Other (Special Properties) and Number or Rulate)  e(s) and manner as and place, and due  Date signed (Month)	topsy findings average ompletion of cause 2 No  No  ral Route Numbe stated, to the cause(s)

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

State

Registrar

Year)

32. Registres Signature

2008

			Please 1	Type or Prin									
			For State Registrar	State of Ma	iryland /		tment of F ificate of		Mental Hy	giene Reg. No	anna.	126	598
D.	Dhoolel		1. Decedent's Name (First, Middle, Last	)					2. Date of De Month	eath Da	y Year	3. Time of	
ě	Physicia /Medic	-	Flor	ence Ethe	1 Holle				April	10	2008	1059	A <sup>™</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4		or Location of Deat	th	4c.	County of Death		
			Union Hospital		- /l	:	E1kto		8. Date of Bi	rth	Cecil	place (State o	r Foreign
7	Funeral Director		5. Social Security Number  202-10-0120  Usual Residence of Decedent	x 7. Agi 1 M 2 X F 8	(In yrs. last b		Months Days			ay, Ye <i>ar)</i>	Con	nsylvar	
	show ad at	J.	10a. State 10b. County		10c. City, Tov		tion					10d. Inside Cit	
	the M 28a-f otifie	ecto	Maryland Cecil  10e. Street and Number		E1kt	on	10f. Zip Code			10a. Cit	tizen of What Cou	intry?	
	a or	ă					2192	1			nited St	-	
	eath	eral	420 North Street	12. Was Decedent	Ever in U.S.	13. Wa			Specify Yes or N		14. Race - Amer		
36	be filed within 72 hours after death with the Maryland that Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Directo	1 ☐ Never Married 2 ☐ Married  3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:		_	Yes, specify Cut □Yes 2[X]No	Hispanic Origin? (S pan, Mexican, Puer Specify:	rto Rican, etc.)		Black, White  Specify: W	, etc. nite	
Ş	2 hou	ed	15. Decedent's Edu	ucation	168		nt's Usual Occu			16b. K	ind of Business/I	ndustry	
21215-0036	in "n In "n Medi	Be Completed by	(Specify only highest grad	College (1-4or 5	i+)	life. DC	na of work done O NOT use retire	e during most of wo ed)	orking				
212	d with giene er tha	ĕ	10		<u> </u>	Hom	<u>emaker</u>				n Her Ow	n Home	
	al Hy al Hy othe	3e (	17. Father's Name (First, Middle, Last)						me (First, Middle	-	n Surname)		
<u>Ja</u>	should be filed within 7 and Mental Hygiene. s marked other than "numatic event, the Med	2	Edward Snyder					1	nce Blan				
Maryland	01 10 07 65		19a. Informant's Name/Relationship (7)			-		t and Number or F				ip Code)	
2,	1 and 2 Health em 27		Bernadine Eva/Da	ughter			tion (Name of	reet, Ell	Date		921 ocation - City or	Four State	
Ore	ges 1 t of F If ite or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	Schuv	ery, crema	atory or other pla Memori	Apr	il 14,	1	•		D.
Ë	t. Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Specify		Park			2000			uylkill	Haven,	PA
Baltimore,	permit. Pages 1 ar Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licens	romin	)	Hic 103	ks Home 3 W. Sto	ess of Facility for Fun ockton St	erals, reet, E	P.A. 1kto	n, MD 2	1921	
٠.			23a. Parts. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each li	the death. Do	not enter	the mode of dy	ring, such as cardia	ac or respiratory	arrest,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	Ph	cumo	, we						1 che	Dealii Loo
	/Medical		resulting in death)	Due to (or as	a consequence	e of):							3
	Examiner	ارا	Sequentially list conditions,	b									
	D iii	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as	a consequence	e ot):							
	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	c	a consequence	e of):							
60,		Ë		Duc 10 (01 as	a concequence	5 617.							
68760	ficate be e physician s the buria	gi		d									
. Box	ath certii attending for use a	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal dea		Ectopic pregnan Other (specify)	су		ł	23d. Date of deli Month	•	Year
P.0	that the de ned by the a detached t	Phy	9 Unknown		tataultin.ee	in the up-	dorhina cauco a	iven in Bort I	230 Did	Ltobacco	use contribute to	the cause of a	doath?
	res th igned	þ	Part II. Other significant conditions of					even in Fait i.			2 No 3 □ Pr		
ord	w requir been si should	ted	muli,	le epis				one				Obably 4 🗔	OTRIOWII
Records,	law las be	Completed	Mypereiricec	nie	kin	C	AF	cma.	24a. Wa	opsy	prior to o	topsy findings completion of c	available ause of
<u> </u>	ian: The l rtificate ha	NO.	Mod cortie	Stenosi	~				per 1□ Yes	formed2 2 ☑ N	o death? o 1 ☐ Yes	2□ No	
Vital	sician: certifica rector,	Be (	25. Was case referred to medical examiner?	Hamitali			lo		eath (Check only	one)			
or	Physician: r this certifica ral director, I	은	I Tes ZONO	Hospital:			3 DOA				6 ☐Other (Spe	cify)	
Division (	ing Affe	ation:	27. Manner of Death    1   Natural   5   Pending investigation   3   Suicide   6   Could not be	28a. Date of Inju (Month, Da		. Time of Injury	28c. Inj W M 1[	ury at ork? □ Yes 2 □ No	28d. Describe	e now inju	ury occurred		
Very star of the s						n (Street and Number or Rural Route Number, Town, State)							
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		ysician: To the best niner: On the basis of and manner st	f examination								s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier					nse number			ate signed (Mont	h, Day, Year)	
			Mamita +	luli n	0		1	5063	730	4	110/08		

State Registrar

31. Date filed (Month, Day, Year)
APR 1 8 2008

UNION HOSPITAL ELIKTON 32 Negistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registra MEND#5, 10c, &18, perFH, 4/14/08, DPS, McGertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** Ам 28, 2008 12:40 William W. Hull March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 463-01-6875 6. Sex Months 12 M 2 F 93 May 18, 1914 Texas <del>453-01-6874</del> Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Charlotte Hall 1 X Yes 2 ☐ No Director St. Mary's Charolotte Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 Charlotte Hall Road U.S.A20622 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No 1945—
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: White Specify: 3 XWidowed 4 Divorced Year or Dates: 1946 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Army Corps of College (1-4or 5+) Elementary/Secondary (0-12) Engineers 4 Clerk 18. Mother's Name (First, Middle, Maiden Sumame)
Laura Baxtine 17. Father's Name (First, Middle, Last) Be 2 <del>Laura Baxtinel</del> Mason L. Hull Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44084 Grape Ivy Lane California, Maryland 20619 19a. Informant's Name/Relationship (Type, Print) Helen L. Hull/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Date 20c. Location - City or Town, State 20a. Method of Disposition April 3, 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cemetery Washington, D.C. 22. Name and Address of Facility 21. Signature of Funeral Servive Licensee DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic on Kidney Jeans Due to (or as a consequence of) pertension pr as a consequence of): pans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dup to ( Examiner Mellitus betes en sclenotic Cardio vascular Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Difficile 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown ermittent Gastrointestinal 24b. Were autopsy findings available prior to completion of cause of death? Bleeding 24a, Was an autopsy performed My Pothy roidisms 2 No 1 Yes 2 No 1 Yes 25. Was e referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Powering Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZNo 10 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 🗌 No 1 Tyes investigation 2 Accident

Physician /Medical **Examiner** burial-transit The law requires that the death certificate be executed Box 68760 the P.O. signed b Records, Division of Vital or Attanding Physician: After the death. **Director:** within 24 hours a

To tha Funaral I

completely filled To the I

**Funeral** 

Director

show

Itams 23a or 28e-f shor

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Itan any njury or other traumetic evant, it a Medical Examinations.

21215-0036

Baltimore, Maryland

Certification: 29b. Signature and the of certifier

Medical

6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 28

of death (Item 23a) (Type, Print) Paru) S Hospita te 31. Date filed (Month, Day, Year)

State Registrar

0 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3Ó, 2008 4:20A. March Horenberg Shelly E11en /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year)
Aug. 22, 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🛣 F Months Maryland 1935 72 Director 579-48-8714 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1X Yes 2 No Annapolis Anne Arundel Director Maryland 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or U. S. A. 21401 2939 Broad Court Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Family Owned Insurance College (1-4or 5+) marked other than Elementary/Secondary (0-12) 9 Comapny 12 Years Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked oth Be Leah Fried Hyman Posner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theodore H. Horenberg - Husband 2939 Broad Court, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any Injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/2/2008 Olney, Maryland Judean Mem. Gdns 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licensee 20852 Donala Cottlemyer 23a. Part1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Jepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year jo in the past 12 months? 5 Other (specify) ☐ Yes 2 No detached the 9□Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe Kenal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen tailure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No VSV). 24a. Was an autopsy pertormed? Yes 2 No has certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2/ No 1 🛛 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: Injury Attending (Month, Day Year) 1 Natural 5 Pending investigation To the Hospital C. within 24 hours after death.

To the Funeral Director: After the Funeral Director: After the Funeral Director: After the funeral pilled in by the funeral Director. 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 03 2008 APR

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lway anna polis, or

D 46052

3/30/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 8:55 AM<sup>M</sup> March 31, 2008 Hayman Stanley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 11400 Strand Drive #110 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 XM 2 □ F Washington, 9/21/1914 93 **Director** 577-01-9976 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County r 28a-f show notified at 10a. State 1 X Yes 2 □ No Rockville Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 a or death with 11400 Strand Drive #110 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give WW T 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White WW II þ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cash Register Owner is 1 and 2 should be filed voil Health and Mental Hygie item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Debois Benjamin Hayman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15 Arlive Court Rockville MD 20854 Richard W. Hayman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Memorial
Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/2/08 Olney, MD 22. Name and Address of Facility 21. Signature of Funeral Pervice Licensee Edward Sagel Funeral Direction Inc. 20852 Approximate Interval Between Onset and Death 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Bronchial Asthma
Due to (or as a consequence of): attending physician and for use as the burial-trai IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ned by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ been signe should be d 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation, Chronic Renal Failure, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Coronary Artery Disease autopsy performed? cate has 1□ Yes certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical To Be Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 27. Manner of Death After Certification: Injury 1 Natural 5 Pending investigation within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

Division or Vital Records,

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I



State Registrar

Medical

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D23170

29c. License number

29d. Date signed (Month, Day, Year)

April 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Physician Samue 4 Ven /Medical 4c. County of Deat 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** mon Be 5050 a 23460 burban If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birinplace (State or Foreign Sountry) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 1921 New York 124-18-8366 86 Nov. 11, **Director** Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Palm Beach West Palm Beach 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 471 Wellington J 33417 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No. White Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Advertising Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Molly Horszowski Pages 1 and 2 should I ပ Philip Habenstreit Department of Health and Nimportant: If Item 27 is ma any Injury or other trauma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Potomac, MD 20854 9024 Roven Lane Paul Haven - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4/3/2008 4 Donation 5 Other (Specify) Menorah Gardens West Palm Beach, Florida 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** C/2561 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner to Oh Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MOSC P The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical tending por use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant □Ectopic pregnanc Month Day Year in the past 12 months? 5 Other (specify) 2 🗆 No the detached 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Yes 2 1□ Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death.

I Director: After this d in by the funeral di 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospitai or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 No પ્ટ હ 2 Accident 7000 Mar 3/2008 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) (Street and Number of determined 4 ☐ Homicide Rockull NUrgin Home To the Hospital within 24 hours a To the Funeral C completely filled 1x Certifying Physician: To the best of my k and dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl April 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Willie C. Blair 7525 Greenway Center Drive Greenbelt MD 20770 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** ROLAND HALL 503 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTOOMERY PARIL ADVENTIST WASHINGTON HUSPITAL TAKOMA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | 29 | Min. | Mar. 19, 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1**☑** M 2□ F Maryland 79 Director <u>Unknown</u> Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Ex-miner must be notified at 1 ☐Yes 2 ☐ No Director MD Prince Geo Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or in important: If item 27 is marked other than "natural", or items 23a or in items in items 23a or in items in items 23a or in items it 4207 Byers Street 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Laborer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Hall Bessie Marr P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Hall (Daughter) 4207 Byers St., Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Riverdale, MD Riverdale Pk Crem 4/1/08 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signat re of Funeral Service Lice see 246 N. Washington St, Rockville, MD 20850 XI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an 1 | Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 A Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

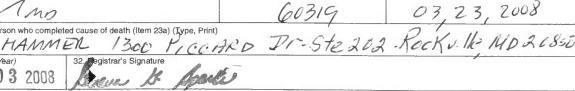
State Registrar

31. Date filed (Month, Day, Year)

DARCIE

03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUALLAND I LOWI JULIUS 2517 ( If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 M 2 XF 213-14-1702 86 9/15/1921 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene. nt: If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show be notified at 10a State 1 ☐ Yes 2 No Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA "natural", or items 23a edical Examiner must b 10218 Old Ocean City Blvd. Apt.1004 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 Nowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cafeteria Service 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Mitchell Mildred Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. 9426 Libertytown Rd., Berlin, MD 21811 Barry Hastings / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cape Henlopen Crem. 4/4/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) The Burbage Funeral Home 22. Name and Address of Facility 21. Signa 108 William St., Berlin, MD 21811 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESO, RATOR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SLRHAG BREAKHEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): certificate be executed WILL SALTH that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as use yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy Month Day Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? CIEWAT page 2 s certificate has 2□No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA 1 🔲 Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 5 Pending investigation 1 Natura! 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA5

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 04

2008

**ORIGINAL** 

32. Registrar's Signature

2 Show 10

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** :10 2008 HIMES LUELLA BARBARA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Min MARYLAND MARCH 8. 1914 94 Director 219-12-1765 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND WASHINGTON HAGERSTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 111 GRAND OAK DRIVE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ WHITE 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EMORY OSWALD POTTER LULA ELIZABETH SPENCER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 GRAND OAK DRIVE, HAGERSTOWN, MARYLAND 21740 JEAN M. HOLMES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of h Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/10/2008 | BOONSBORO, MARYLAND BOONSBORO CEMETERY 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Kelly A. Zimmerman Boonsboro, Maryland isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, alture. List only one cause on goth line. Approximate Interval Between Onset and Death Week Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mor 4□Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy nerform 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 🔲 Yes င္ 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

03H-3

State Registrar

ΔPR 0.8 200

30. Name and addr



who completed cause of death (Item 23a) (Type, Print)

40

11110 Medi

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

12705

			1 - State Registrar		C	ertificate of l	Death		Reg. No.	00 12700
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	3. Time of Death
	Physici /Medio		Dencil Darrell HU	FFMAN				April	01, 2	.008 10:19 8·w
	Examir	er	4a. Facility Name (If not institution, give	*			r Location of Deat	h •	4c. County	
			Washington County				gerstown I if Under 24 Hrs.	O Date of Bird		nington
	Funeral Director		214-09-7254	X M 2 F 7. Ag	ge (In yrs. last birthd 91 Yrs	Months Days	Hours Min.	8. Date of Birt (Month, Da March	y, Year) 4,1917	9. Birthplace (State or Foreign Country) West Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	ğ	Maryland Washi	neton	Ная	gerstown				1 ☐ Yes 2 🔼 No
	r 28a	Director	10e. Street and Number		1100	10f. Zip Code	-		10g. Citizen of W	/hat Country?
	h with	<u>=</u>	11032 Clinton Av	enue			21740			USA
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of H     If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-	- 14. Race	- American Indian, k, White, etc.
980	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ð	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∑XYes 2 ☐ If Yes, Give Year or Dates ₩	Nº1942-45 WII	1 ☐ Yes 2 🖾 No	Specify:	o i noun, c.c.,	Specify:	
5-0	72 hc natu	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De	cedent's Usual Occup ive kind of work done of e. DO NOT use retired	ation during most of wo	rking	16b. Kind of Bu	siness/Industry
21215-0036	should be filed within of Mental Hygiene. marked other than "imatic event, the Meg	Completed	Elementary/Secondary (0-12)	College (1-4or 9	5+)	et metal l			sandbl	lasting
Maryland	be filed ital Hygi id other event, til	Be (	17. Father's Name (First, Middle, Last)				77.00		, Maiden Surname	e)
yla	should the marker umatic e	ျ	Den Huffman					e Jerdon		
lar	2 8 8		19a. Informant's Name/Relationship (7			ailing Address (Street				
	is 1 and 2 of Health Item 27 i		Cynthia A. Sense:	nbaugh-dai		L925 Dormay sposition (Name of	yne Dr.,	Hagerst		21/42 City or Town, State
Ö	0 0 - <u>-</u>		1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, o	crematory or other plac				
Baltimore,	permit. Pag Department Important: I any injury o		4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		Kose Hi	.11 Cemeter		.0/08	_	own, Maryland
Ba	permit. Departr Importa any inji		21. Signature of Fune abservice Licen	-MM	Tunne (	Name and Address			UNERAL H	
	Physician /Medical		23a. Patt. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ather	ne. Osclaw315					Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequence of):					
I.		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):					
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	ertificate be executed ling physician and e as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
68760,	te be ysicia e bur			d						
	tificate t g physias the k	Medical								
.O. Box	The law requires that the death certificate has been signed by the attending ptrage 2 should be detached for use as t	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date Mor	e of delivery nth Day Year
<u>α</u>	that ned b		Part II. Other significant conditions of	ontributing to death b	out not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
rds	w requires been sign should be	ed by						10	Yes 2□16	3 ☐ Probably 4 ☐ Unknown
Division or Vital Records,	(0	Completed						24a. Was autop perfo 1□ Yes	ormed? 🦯 d	Were autopsy findings available prior to completion of cause of death?  □ Yes 2□ No
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only c	one)	
7	Physic this c	ပ္	1 Ves 2 No	Hospital: Inpatio			4 LI Nursing F	T	dence 6 □Othe	
no O	ing After une	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim ay Yea <i>r)</i> Inju	y Wor		28d. Describe I	how injury occurre	ed
Sic	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		At home form		Yes 2 No	206	C44	
Divi	ital or Attendrs after death ral Director: ,	Certification:	4 Homicide determined	building, et	tc. (Specify)	street, factory, office		City or Tov	wn, State)	er or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory (Completely filled in b	Medical	29a. Certifier  (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination and/o	eath occurred at the tir r investigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	unner as stated. and due to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	1 01		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
			MIKIM	12 PV	451cm	U.	56783		April	0, 2ws
اك	4-8+1		30. Name and addless of person who	empleted cause of c		pe, Print) Ma	edical (	impus t	ed. Hac	PERSTOWN MO

State

31. Date filed (Month, Day) Year)
APR 0 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 3, **Physician** 0200 2008 Robert Stanley House /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Friendsville 949 Old River Rd., Apt. D-5 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Jan. 13, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days 1**⊠**M 2□F 1937 Maryland 71 Director 232-56-6876 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other then "naturel", or Items 23e or 28e-f show treumetic event. It e Madical Examiter must be notified at 1X Yes 2 No Director Friendsville MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21531 USA 949 Old River Rd., Apt. D-5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Timber Logger 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tent: If item 27 is marked ot Be ပ Lillian Elizabeth Glotfelty Sherman William House 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree once. 436 Ron Georg Rd., Accident, MD Eleanor L. Georg/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State April 2, 2008 Friendsville, MD Steele Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fymeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. Ljui 21536 P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician COPI 2910 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Cther (specify) signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation Natural s after decrei rel Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a

To the Funerel I

completely filled To the Hospitel Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 100 MIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR - 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Fetus Isaac 1- For State Certificate of Death Reg. No Registrar Time of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 3, 2008 1655 hrs **Medical Examiner** MaryGrace Isaac 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince Georg'e Hospital Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 5 Director 04/03/2008 Country) Maryland Unavailable 2X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 10a State 1 X Yes 2 No Maryland Prince George's Capitol Heights must be notified at once, Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20743 324 Carmondy Hills Drive 14. Race - American Indian, Black, Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year 1 Yes 2 X No specify: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. Divorced Widowed Black á 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Isaac Princess Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmondy Hills Dr. Capitol Heights, MD 20743 Frederick Isaac - Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Ft. Lincoln Cemetery 04/12/2008 Brentwood, Maryland Other Specify: Donation 5 22. Name and Address of Facility Fort Lincoln Funeral Home Service Licer anature of Fune 3401 Bladensburg Rd., Brentwood, MD Approximate Interval 23a. Part I. Winter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Congenital Pneumonia Complicated by Prematurity Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 23a, Pt.II, 27 per ME g879 5/2/08 amh X UNPENDED the attending physician ed for use as the burial requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Acute Placentitis Choricamnionitis & Funisitis; Completed 24b. Were autopsy findings available 24a. Was an certificate has been Retroplacental Hematoma with Focal Placental Infarction prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 this 1 V Yes ို 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural Division Yes 2 No urs after death. Pending 2 \_ Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) within 24 hours at To the Furneral I determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 4, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day Year APR 1 1 2008 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh e79 5-27-08 yt. State of Marviane 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FRANK MARCH 31ay, MARCELL **JACKSON** 2008 6:35 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7309 Chrome Mine Road Gaithersburg MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | Min. | Mar. 13, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **№** M 2 🗆 F Maryland -9518 Vrs 703 - 985 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Chrome Mine Road 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: 45-47 1 ☐ Yes 🏖 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Bureau Elementary/Secondary (0-12) College (1-4or 5+) 6th Janitorıal Supervısor of Standards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Jackson Hester Sims 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jackson (Daughter) 7309 Chrome Mine Rd, Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burjan 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/11/08 Veterans Cem Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Dia 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident
Due to (or as a consequence of): 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2**X** No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

The law requires that the death certificate be executed the burial-transit attending physician and Division or Vital Records, P.O. Box 68760. signed by within 24 hours after death.

To the Funeral Director; After this certificate To the Hospital or Attending Physician; filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

2

Completed

Be

2

Certification:

Medical

**Funeral** 

Director

Show

or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the once.

Physician

/Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner 1 Yes 21 No 27. Manner of Death 1 🔀 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/31/08 D44157

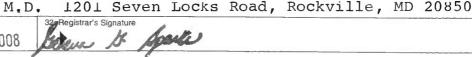
State Registrar

DHMH 17 Rev 1/2001

Ira Berger, 31. Date filed (Month, Day, Year)

03 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			_ For	ate of Maryland				d Mental Hy	/giene	Э	
			1 - State Registrar		Cer	tificate of L	Death	0.0-1-10	Reg. No	200	8,12710
	Physicia	an	Decedent's Name (First, Middle, Last)	1				2. Date of D	Da	y Yea	
	/Medic	Secret St.	Randy Sue Katzelnic  4a. Facility Name (If not institution, give stree.			4b. City. Town, or	Location of De	March		County of De	3:08 P M
<b>)</b>	Examin	er	Shady Grove Adventi			Rockvil				Montgo	merv
-,00	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Bi	rth	9. E	Birthplace (State or Foreign Country)
	Director		082-54-2705 <sup>1□ M</sup>	<sup>2</sup> X F 49	Yrs.	Months Days	Hours M	Nov. 1			ew York
	put •		Usual Residence of Decedent  10a, State 10b, County	10c. City, T	own or Loc	ation					10d. Inside City Limits
	Maryle f sho ed at	ğ									1⊠Yes 2□No
	the N 28a-	Director	MD Montgomery  10e. Street and Number	North	1 Pot	10f. Zip Code			10g. Ci	tizen of What	Country?
	3a or	Ö	13934 Saddle View D	rive		20878	,		U.S	S.A.	
	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11 Marital Statue 12. V	Vas Decedent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin?	(Specify Yes or N	0-	14. Race - Al Black, W	merican Indian,
õ	after or ite		1 ☐ Never Married 2 🔀 Married 1	☐Yes 2XNo Yes, Give		☐ Yes 2⊠ No	Specify:	Total Thousand Octoby			White
0000	hours ural";	d by		'ear or Dates:	ISa Dagad	ent's Usual Occup	ation		16h k	(ind of Busine	
'n	n 72 i "nat ledica	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	(Give life. L	kind of work done o OO NOT use retired	during most of v ()	working	100.1	and of Eusine	ss/Industry
7 7	iene.	E O	Elementary/Secondary (0-12) C	College (1-4or 5+)	Bi11	Collecto	r		l M	iedical	
2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle	e, Maider	n Surname)	
	should by and Menta s marked umatic ev	2	Stuart Beloff				Fae I	Kleinman			
9	2 sho and l is ma rauma		19a. Informant's Name/Relationship (Type. F	Print)	19b. Mailin	g Address (Street a	and Number or	Rural Route Num	ber, City	or Town, State	e, Zip Code)
2	and lealth m 27 her tr		Jeffrey A. Katzelni					rive N. F			20878 or Town, State
2	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Remo	vai irom State		sition (Name of natory or other plac	1			,	,
	регтіі. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	King		d Mem. Go Name and Addres		30/08	Fal	ls Chui	cch, Virginia
ם ח	permit. Departn Importa any inju		Sonald C. D	tottlemy	. ,  Ed	ward Sago 91 Rocky	el Fune	ral Dire	ction	n, Inc.	20852
4			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the eath.	Do not ente	er the mode of dyin	g, such as card	diac or respiratory	arrest,		Approximate Interval Between
,	Physician	1	Immediate Cause (Final disease or condition	Pneumonia							Onset and Death  1 week
ð.	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						
	L A MA	<u>.</u>	Sequentially list conditions, b. —	Due to (or as a consequen	ice of):						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequer	ice oi).						
,	execunand and and all-tra	Examiner	resulting in death) Last	Due to (or as a consequer	ice of):						
00/	cate be executed physician and s the burial-transit	dical									
0	rtifica ng ph as th	Vedi	IF FEMALE:						Т		
Z C	ath ce tendii or use	an/l	23b. Was decedent pregnant	f yes, outcome pf pregnanc I □Live birth 2 □ Fetal de	eath 3	Ectopic pregnancy				23d. Date of Month	delivery Day Year
5	The law requires that the death certific the law requires that the last been signed by the attending page 2 should be detached for use as	Physician/Me	1 Ves 2 X No	I□Pregnant at time of deat B□Unknown	h 5□	Other (specify)	·			monar	Day 10th
Ľ	that the ed by detac		Part II. Other significant conditions contribu	iting to death but not resulting	ng in the ur	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute	e to the cause of death?
cords,	uires signi ld be	Completed by	Diabetes, Morbid Ob	esity				1	Yes 2	2⊠ No 3□	Probably 4 ☐Unknown
5	w req	lete						24a. Wa	s an	24b. Were	autopsy findings available
ב	The la te has age 2	J W						— auto peri 1□ Yes	opsy formed? 2⊠N	death	to completion of cause of i? 'es 2□ No
ב	lan: rtifica stor, p	യ	25. Was case referred to medical				26. Place of I	Death (Check only		0 13.	C3 2 110
	hysic his ce direc	To B	examiner? 1 ☐ Yes 2 No Hospi	1 X Inpatient 2 LEH	/Outpatien	t 3□ DOA Oth	er: 4 ☐ Nursin	g Home 5 ☐ Res	sidence	6 □Other (S	pecify)
	Ing P		1 ☑ Natural 5 ☐ Pending	8a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	28c. Injur Worl		28d. Describe	how inju	iry occurred	
2	ttend leath tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Po Place of injuny. At home	form etr		Yes 2 □ No	20t Location	/Ctmot o	nd Mumbara	Rural Route Number.
2	al or A s after al Direct	Certification:	4 ☐ Homicide determined	Be. Place of injury - At home building, etc. (Specify)	, 101111, 3111	oci, idoloty, onice		Cify or To			nuiai noule ivuilibei,
	To the Hospital or Attending Physician: The law within 24 butous after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.							
	withi To t	Ž	29b. Signature and title of certifier	10	1 -	29c. Licenso	e number		29d. Da	ate signed (M	onth, Day, Year)
)	12		for All	with !	40	D2654	0		Marc	h 26,	2008
(1			30. Name and address of person who comple			ŕ		10 6 1 1	4		20077
1	Sta	to	Carl Schoenberger, 1 31. Date filed (Month, Day, Year)	MD 16220 Fre		ck koad S	uite 2	ان Gaithe	rsbu	irg, MD	20877
	Sta Registr		APR 0 3 2008	Breeze h		anti					
DHI	MH 17 Pov 1/2/	001	Fit 1, 0 0 2000	The Parties of the	- Jak						

08-02723 Michael Kline Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hael Kline		St 1- For State Registrar	ate of Maryla		partme Certifica			and	Menta	al Hy		Reg. No	20	08	3 1271
Physici dical Exami									2	2. Date of Dea Month April 6, 20	Day	Year	3.	Time of Death 1930 hrs	
		4a. Facility Name (if not institution, give street and number)4b. City, Town, or Location of Death4c. County of Death216 West Chapline St.Sharpsburg, MDWashington													
Funeral Director		5. Social Security Number 219-96-7284	6. Sex	7. Age (In y	rs. last birth 39	nday) Yrs.	If Under Months		If Under Hours	24Hrs. Min.	8. Date of Bi			oreian	lace (State or ry)Mary land
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once,	٦.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Sharpsburg									- 1	Od. Inside City Limits  X Yes 2 No			
	Director	10e. Street and Number 216 West Chapl	ine Stree	+	•		10f. Zip C	ode 782				10g. Ci	itizen of What USA	Country	R
	Funeral	11. Marital Status  1 Never Married 2 X Mar	12. Was De	cedent Ever i orces?	-	If Yes	Decedent	of Hispa Cuban, I	Mexican, I		cify Yes or No lican, etc.)	0-		tc.	n Indian, Black,
036 ithin 72 hours and. ne. r than "natura	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	cify only highest gra		d	Decedent's luring mos	st of worki	ng life. D	NOT u				Kind of Busin	ess/Ind	ustry
MD 21 Id 2 should lith and Me In 27 is ma	To Be Cor	17. Father's Name (First, Middle, Joseph Paul Kl 19a. Informant's Name/Relations	ine		19h	Mailing	Address		Kath	y Me	First, Middle,	Sto		State 7	in Code)
		Tonja N. Kline 20a. Method of Disposition		20		6 W.	Chap	line	St.	Sh		rg,	MD 217	82	
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other S	ecita /	om State	cremato miths	_	Cre		, ,						Maryland
		21. Somature of Funeral Societies 22. Name and Address of Facility Osborne Funeral Home, 425 S.Conococheague St. Williamsport 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									ort.	MD 21795 Approximate Interval			
Physician Medical :aminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ound of H	lead	one bre	THIOUG OF	aying, se	3011 03 001	Talac or I	copilatory ar	1031, 3	TOOK, OF WORK		Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):													
cuted ind transit	ıl Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequenc	ce of):										
60, ate be executed hysician and e burial - transit	Medical	UNPENDED  IF FEMALE:	AMENDED	outcome of p	regnancy							12	3d. Date of de	livery	
cords, P.O. Box 68760, Inw requires that the death certificate be executed has been signed by the attending physician and Should be detached for use as the burial - transi	sicia	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth nant at time o	2		I death er (Specif	3	Ectopic	pregnan	су	e.	Month	Day	Year
P.O. res that the signed by t	d by Phy	Part II. Other significant conditi	ions contributing t	o death but n	ot resulting	in the un	derlying c	ause giv	en in Part	t I.					cause of death?
The cate	Completed										1 Yes		prio deat	r to com	sy findings available apletion of cause of
on of Vital I ending Physician: eath. or: After this certifi the funeral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Out	tpatient	_	10	f Death (C			Resid	lence 6 🗸 C	Other: S	cene
		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury 1925 hrs  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred Subject shot self													
Division  To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide deter	d not be mined (Specify)	e of Injury - A	e					2	or Town, 1 16 West Ch	State) apline	St, Sharpsb	ourg, M	Route Number, City
Fo the JE within 24 Fo the Fr completel	Medical	one) 2 Medical Exam	nysician: To the bearing miner: On the basis and manners	of examination			n, in my c	pinion, d	teath occu						ause(s)
	Σ	29b. Signature and the of certifie	11	m				icense r				Ι.	Date signed	(Month	, Day, Year)
OCME H-8		Mary G. Ripple MD.	who completed cau Deputy Chief I	Medical E	xaminer	111	Penn S	treet, E	Baltimo	re, MD	21201				
St Regis	ate	31. Date filed (Month, Day, Year)	8 2008 32. R	egi ar's Sigr	nature	10		P							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 27, 2008 Physician Рм 5:15 Robert L. Kinser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Bowie 2611 Kennison Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 79 1929 Ohio Director 285-24-2422 Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any lour or 2 is marked other than "natural", or items 23a or 28a-f show any loury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1√ Yes 2 No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 2611 Kennison Lane Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Folces:
1 M Yes 2 □ No
If Yes, Give
Year or Dates: 1948-52 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Communications Officer Intelligence 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances M. Branum Clifford L. Kinser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2611 Kennison Lane Bowie, MD 20715 Craig Kinser/ Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Mt. Comfort 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/1/2008 Alexandria, VA Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 9st Pokyce 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic cancer 6 months **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Emphysema 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3.31.08 D 26492 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Mitchellville Rd #B216, Bowie, MD 20716 Riad Dakheel, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please T						re All Copi		_		
			1 - For State Registrar	State of M	aryland		rtment of F tificate of		ind Mental I	Hygier Reg. N	2006	3 12713	
1	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date o Month		Day Year	3. Time of Death	
	/Medic			rson L	ee			Apri		1 2008	0740 A M		
	Examin	er	4a. Facility Name (If not institution, give s 307 Maloney Road	reet and number)			4b. City, Town, c		Death		c. County of Deat	п	
T	Funeral		5. Social Security Number 6. Sex	ge (In yrs. las	t birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. Date o	f Birth , Day, Yea	h 9. Birthplace (State or Foreign			
	Director		214-20-4716   1 M 2 M F   81			Yrs.	Months Days	Hours	AUG 2			ryland	
	and aw		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Mary I-f sho fied a	tor	Maryland Cecil		E	lkton					1 □Yes 2 ሺ No		
	th the	Jirec	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Co	untry?	
	ath w	ral	307 Maloney Road			140	21921		: 0.00 · :t- V		United S		
	be filed within 72 hours after death with the Maryland tall Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 🕅 Married	<ol> <li>Was Decedent Armed Forces</li> <li>1 ☐ Yes 2 X</li> </ol>	?				gin? (Specify Yes o , Puerto Rican, etc	r N-0- .)	Black, White		
920	urs af al', or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2∏ No	Specify:			Specify: W	hite	
5-0	72 ho 'natur dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most	of working	16b.	Kind of Business/	Industry	
121	e filed within 7 al Hygiene. I other than "r vent, the Med	Completed	Elementary/Secondary (0-12)	5+)		inistrat				Insuranc	e		
d 2	i filed I Hygi other ent, tl	ပိ	17. Father's Name (First, Middle, Last)		l l				r's Name (First, Mi	ddle, Maid			
/lan	uld be Menta wrked artic ev	To Be	Lewis Peterson					Anni	le Rothwe	11			
<b>dan</b>	2 should be f and Mental I Is marked of raumatic eve		19a. Informant's Name/Relationship (Typ	,			•		r or Rural Route N				
ore, N	D = C =		Walter E. Lee/Hus 20a. Method of Disposition	band	20b. Plac	ce of Dispo	sition (Name of	1	Elkton,		and 2192 Location - City or		
	0 0		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	·		matory or other pla emetery	A	pril 16, 008		Elkton, N		
altir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	е					Funerals,	TD A	LIKCOH, I	110	
<u> </u>	20 E # 8		Danied S.	Hick	2	10	13 W. Sto	ckton	Street,	Elkto	on, MD 2	1921	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each I	d the death. ine.	Do not ent	er the mode of dyi	ng, such as	cardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a conseque	StA	St						
	Examiner			HORTI	C S	TENC	ISIS						
	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque								
	be executed ician and burial-transit	Examine	that initiated events cresulting in death) Last	Due to (or as	a conseque	nce of):							
68760,	e be es sician buria	_											
.89	rtificat ng phy as the	Media	IF FEMALE:										
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Fetal d	eath 3	Ectopic pregnanc	у			23d. Date of del Month	ivery Day Year	
o.	that the de ned by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	tn 5L	Other (specify) _			_			
Δ.	res that igned by be deta	by Ph	Part II. Other significant conditions cor	tributing to death I	but not resulti	ng in the u	nderlying cause gi	ven in Part I.	23e.	Did tobacc	o use contribute to	the cause of death?	
ords	w require been sig should b									1 🗌 Yes	2 <b>□</b> No 3□Pi	robably 4 □Unknown	
Vital Records,	has be	Completed								Was an autopsy	prior to	utopsy findings available completion of cause of	
a			05.14						1 1			2 □ No	
Zi		o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 □ Inpat	ient 2 ☐ El	R/Outpatier	nt 3 DOA Ot	har:	rsing Home 5	/	6 ∏Other (Spe	cify)	
n or	ding Phys		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inj	ury 2	8b. Time o			4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)  at 28d. Describe how injury occurred				
sio	Attending r death. ector: After oy the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	20s Place of in	ium. At hom	a farm at	100	]Yes 2∐t		/O4			
Division	l or At after c Direc	Certification:	4 Homicide determined	building, e	etc. (Specify)	e, iaim, su	eet, factory, office			r Town, St		ural Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 CertifyIng Physics (Check only 2 Medical Examin										
	thin 24 the F	Medical	one)  29b. Signature and title of certifier	and manner s			29c. Licen				Date signed (Moni		
	Viiti To		10 4:10	· Chi	D			6346	9	250.	1/11/08	, Juj, 1001/	
			30. Name and address of person who co	mpleted cause of	death (Item 2	3a) (Type,					11.100		
			Vanessa Villar, N	I.D., 361	Fair	Hi11		Elkton	, MD 2192	21			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	re	20						

		-	For State Registrar	State of Ma		artment of H		and Mental Hy	giene Reg. No.		1 200 000 1 2	
10	t <sub>i</sub>	D.	Decedent's Name (First, Middle, La	ist)				2. Date of De Month	ath	/ Year	3. Time of Death	
	Physicia /Medic Examin	al	Emma S. I 4a. Facility Name (If not institution, given	OWNS ve street and number)		4b. City, Town, or	r Location o	March	30,		9:30P <sup>M</sup>	
	- LAGITIM		Arcola Health	& Rehab.	Center	Silver	SPri	ng		ontgome		
livi Jul	Funeral			Sex 7. Age 1 □ M 2 <b>X</b> F	(In yrs. last birthday,	Months Days	Hours Hours	Min. (Month, Da	ly, Year)	Cot	nplace (State or Foreign Intry)	
	Director		579-70-9689 Usual Residence of Decedent		97 Yrs.			Feb 22	2,19	11   11	gínia	
	yland iow at		10a. State 10b. County		10c. City, Town or L						10d. Inside City Limits	
	a-f sh	ctor	MD Montgo	omery	SIlver	SPring					1 X Yes 2 □ No	
	or 28	Dire	10e. Street and Number			10f. Zip Code 209	002		10g. Cit	izen of What Coi USA		
	sath w	era	901 Arcola Ave	12. Was Decedent B	Ever in U.S. 13.			gin? (Specify Yes or No	)-	14. Race - Amer		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexicar Specify:	gin? (Specify Yes or No I, Puerto Rican, etc.)		Black, White		
21215-0036	2 hou latura ical E	Completed by	15. Decedent's E	Education	16a. Dece	edent's Usual Occup	ation	t of working	16b. K	ind of Business/l	ndustry	
215	thin 7 e. an "n Medi	agu	(Specify only highest gi	College (1-4or 5	+)	e kind of work done DO NOT use retired		or working				
	led wi lygien ner th nt, the		12	4)	H	<u>ousewife</u>		er's Name (First, Middle	Maiden	Privat	.e	
and	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Las Washington	" Shepherd				·	ight			
Maryland	d 2 should be filed within 'h and Mental Hyglene. 7 is marked other than "' traumatic event, the Mec	은	19a Informant's Name/Belationship	(Type, Print)	19b. Mail	ing Address (Street			_		(ip Code)	
S	nd 2 satth ar 27 is r trau		Carolyn Lowns/	Daughter- Law	- in 441 Wash	19th Sti	ceet, DC	er or Rural Route Numb NE 20002				
ē,	of Health item 27		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. L	ocation - City or	Town, State	
m	Page nent c ant: If any or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Marylan	d Nation	nal A	Pril 4,08	La	urel, I	MD	
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Lice	lee	3	821 14tl	n STr	ceet,NW,Wa	ashi		neral Home DC 20011	
	<b>100</b>		23a. Part 1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused y one cause on each lin	the death. Do not en	nter the mode of dyi	ng, such as	cardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition a Endometrial Carcinoma									
4	/Medical Examiner		resulting in death)  Due to (or as a consequence of):									
	LXuiiiiioi	<u>_</u>	Sequentially list conditions,	b	a consequence of):							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
Ć,	be executed ician and burial-transil	Exal	that initiated events c.  Due to (or as a consequence of):									
760,	ysicia ysicia	g	•	d								
89	certifical	Medi	IF FEMALE:									
O. Box	death e atter d for u	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	y			23d. Date of del Month	ivery Day Year	
P.O.	requires that the een signed by the rould be detache	, Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I	. 23e. Did	tobacco	use contribute to	the cause of death?	
ds	juires n sign lid be	d b						1	Yes 2	PI No 3 □ PI	robably 4 Munknown	
Records,	sw req	lete						24a. Was		24b. Were au	utopsy findings available completion of cause of	
	The la	l mo						perl 1□ Yes	opsy formed? 2 X N	death? o 1 ☐ Yes	_	
ita	sician: The law certificate has birector, page 2 s	Be C	25. Was case referred to medical examiner?					e of Death (Check only				
> -	Physician: this certificanal director,	10	1 Tes 2 No	1	ent 2 ER/Outpati	ent 3 DOA		ursing Home 5 Res			cify)	
n	ng fter	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time Ly Year) Injury	Wo	ıryaτ ork? ]Yes 2.[	28d. Describe	now inju	ary occurred		
Division or Vital	Attending r death. ector: After by the fune	icati	2 Accident investigati 3 Suicide 6 Could not	be 290 Place of in	urv - At home, farm, s				(Street a	nd Number or R	ural Route Number,	
Di	after Direction by	ertif	27. Manner of Death  27. Manner of Death  28. Date of Injury  28.									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 ertifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination and/or	ath occurred at the t investigation, in my	time, date a opinion, de	nd place, and due to the ath occurred at the time	e cause( e, date a	s) and manner a nd place, and du	s stated. e to the cause(s)	
	To th Within To th comp	Me	29b. Signature and title of certifier	0 2	/),	29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year)	
	7-	4	( Dan 1	Lea	alla	1 D52	261		Ma	rch 31,	2008	
			30. Name and address of person wh				, -			350 0	2010 1404	
	35		Alan R. Segal, 31. Date filed (Month, Day, Year)		Forest C	Len Roa	d, S	ilver Spr	ıng	, MD 20	1910-1484	
	St Regist	ate rar		32 Regist		enfe)						

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	•	artment of H <i>rtificate of L</i>		/lental Hy	giene Reg. No	2006	12715		
П			1. Decedent's Name (First, Middle, La	ist)				2. Date of De	eath Da	y Year	3. Time of Death		
	Physicia /Medic		Luigi Antonio	Leone				April			1:00p M		
*	Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death			. County of Dea			
. P			11838 Browningsv			Monrovia		0 D-44 D		ederic			
	Funeral Director		577-09-0036	Sex 7. Age (In yrs. 90	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D March	27, Yea <i>r)</i>	1918	rthplace (State or Foreign ountry) Italy		
	pu. v		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ity, Town or Lo	cation					10d. Inside City Limits		
	aryla sho	ō				lang.					1 ∐Yes 2 ⊠ No		
	the N	ect	Maryland F  10e. Street and Number	rederick		Monrovia 10f. Zip Code			10a. Cit	tizen of What C	ountry?		
	3a or	al Dii	11838 Brownings	ville road		217	70		US		,		
<u> </u>	purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I've Macial Everriber must be notified at once.	/ Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give	I .	Was Decedent of Hi fYes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi	te, etc.		
200 -	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	wwiii 1 □Yes 2 □thNo Specify:  16a. Decedent's Usual Occupation					Specify: White b. Kind of Business/Industry			
21215-0036	ithin 72 ne. han "ne	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give life. I	(Give kind of work done during most of working life. DO NOT use retired)			Ī	,			
N	ed w lygie her tl		3	41		Operat	ing Engi				ion Industry		
and	be fill he fill he fill he fill he defined in the fill he defined in the fill he fill	Be	17. Father's Name (First, Middle, Las Pasquale Leone	)			Rosina C		mber, City or Town, State, Zip Code)  Monrovia, MD 21770  20c. Location - City or Town, State  Silver Spring, Maryland  eral Home Inc.  Silver Spring MD 20901  y arrest, Approximate Interval Between				
Š	hould d Me mark maric	ဥ	10a Informantia Nama/Palatianshin	(Time Print)	10h Mailir	og Address (Street	and Number or Ru	ral Route Numl	lumber. City or Town. State. Zip Code)				
Maryland	d 2 s Ith an 27 Is : trau		,								•		
ē,	s 1 an f Hea item 2	-3	20a. Method of Disposition				,	Date	,				
noi Pages ent of	Pages lent or nt: If i		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cernetery, crematory or other place)  April 5,  Gate of Heaven Cemetery 2008								ring.Maryland		
Baitimore,	permit. Departminitus Importa any Inju once.		21. Signature on Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc.										
<u> </u>	20 E E 9		- Stran Ga	reer	I .						cing. MD 2090		
18	Physician /Medical Examiner pu	Examiner	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C										
58760,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):								
280	ficate phys s the	edical		d									
P.O. Box (	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year			
٠ <u>.</u>	res that t signed by be detad										to the cause of death?		
<u>5</u>	quires n sigr ald be	d by	RECURRENT S	MALL BOWEL	0B57	enctip	N	1 🗆	Yes 2	! □ No 3 □ I	Probably 4 Unknown		
Division of Vital Records,	<b>nysiclan:</b> The law requinhis certificate has been si I director, page 2 should i	Completed	RECURRENT S BLADDER CAN	CER WITH U	ROSTA	my		24a. Was auto perf 1 □ Yes	opsy ormed?/	prior to			
<u>ta</u>	lan: artifica ctor, p	Be	25. Was case referred to medical examiner?				26. Place of Dea						
<u>&gt;</u>	hysic nis ce I dire		1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Res	5 Residence 6 □ Other (Specify)				
C	ding Ph h. After th funeral	Ö.:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl		28d. Describe	scribe how injury occurred				
VISIO	r Attendi er death. rector: / by the fu	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not determined	Yes 2□No	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ם	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Cer	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my kniminer: On the basis of examinated and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occu	, and due to th	e cause( e, date an	s) and manner nd place, and di	as stated. ue to the cause(s)		
	Vithir Comp	Me	29b. Signature and title of certifier	1		29c. Licens				ate signed (Mor			
			Done	mo mo		021	936		4	12/08	3		
	511		30. Name and address of person who	N 65C	THomas	13 JOHN	son de	· FR	EDE.	RICK	21702		
ı	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 3 2	32 Registrar's Signa	ature	with the same							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** April 10, Mary Rita Miller 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/04/1920 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2\□F Yrs. 88 Director 481-16-0245 Iowa Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 27 ie marked other then "naturel", or itema 23a or 28e-f ehov traumatic event, tra Medical Examinar musi ke notifikad at Director 1 Tyes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 29th Place N.W. 20008 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) be filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) professor of English University education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be filt of Health and Mental Hy I frem 27 te marked oth Be James Carl Rush Bernadette O'Meara 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Rush Miller / son 138 W. Church Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any njury or ot once. April 11. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | 2008 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home mexelu +M0122211 106 E. Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) C **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examine that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 Yes 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I or Attending Patter death. Division 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funerel D Hospital 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 16428 30. Name and addres of person o complet dear e o death (Item 23a) (Type, Print) Dr. Casper Cline 300 W. 9th Street, Frederick, MD 21701

Registrar

State

31. Date filed (Month, Day, Year)

APR 1 8 2008

O. Y

Ó

Physicians as; many multer

ORIGINAL

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HORI 2008 BERNARD LEE MOSER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1**X**0 M 2□ F Months Days Hours AUG. 19, 212-38-8695 67 1940 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1XIYes 2 No MARYLAND WASHINGTON BOONSBORO 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 119 LAKIN AVENUE 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 🕅 No Specify: Specify: 3 □ Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVICE MANAGER ELECTRIC UTILITY CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN K. MOSER ISABEL N. FORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA L. MOSER/SPOUSE 119 LAKIN AVENUE, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 5 Other (Specify) 4/09/2008 BOONSBORO CEMETERY BOONSBORO, MARYLAND 21. Signa are of Fu 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final NOUSMALL Iuna disease or condition resulting in death) Due to (or as a consequence of); taphylococcul Intection I week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \to No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Hospital: Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation injury 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural', or

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I once.

Director

Funeral

2

Completed

Be ٩

the Maryland

and 2 should be filed within 72 hours after death with eatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

ul or Attending Physician: The law requires that the death certificate be executed are death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for uses as the burlansif and in by the funeral director, page 2 should be detached for uses as the burlan-transit

Examiner Physician/Medical 2 Completed Be Certification: To

Medical

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

filled in by

To the Hospital within 24 hours at To the Funeral D

State Registrar

29b. Signature and title of cer

**APR 08** 

6 □ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Camous

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

use of death (Item 23a) (Type, Print) 30. Name a

and manner stated.

112 mp 31. Date filed (Month. Day 2008

istrar's Signature

			For State Registrar		State of Ma	ıryland		artment of I stificate of				giene Reg. No. 2	008	12718
			Registrar  1. Decedent's Name (i	First Middle, Las	1)		001	incate or	Doun		. Date of Dea	- 100	000	3. Time of Death
	Physicia	an	Daniel He							,	Month	Day 31.	Year 2008	3:20 A M
2	/Medic		4a. Facility Name (If no					4b. City, Town,	or Location		Mar.	7 .	unty of Death	
	Examin	er						Arno	กได้			Ar	ne Aru	ındel
1	Funeral		60 Dividir 5. Social Security Num	nber 6. Se	x 7. Age	(In yrs. last	t birthday)	If Under 1 Year Months Days	If Unde	r 24 Hrs. 8 Min.	. Date of Birt (Month, Da	h	9. Birth	place (State or Foreign
Ь	Director		075-30-049	99 12	<b>Z</b> M 2□ F	69	Yrs.	Months Days	Hours		Sept.			York
	p ,		Usual Residence of Do			10c. City, T	fown or Lo	cation				_		10d. Inside City Limits
	anyla shov	_		Ob. County Anne Aru	ndel	Arn		oation						1 □Yes 2 ₩ No
	he M 28a-f otifie	ect	10e. Street and Numb					10f. Zip Code			1	10a Citizer	of What Cou	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	60 Divid		k Court			2101	12			USA		
	leath	era	11. Marital Status		12. Was Decedent I	Ever in U.S.	13.	Nas Decedent of Yes, specify Cu	Hispanic O	rigin? (Speci	fy Yes or No	- 14.	Race - Amer	
(0	or iter		1 Never Married	2 Married	Armed Forces?	lo 1962					can, etc.)		Black, White	
က္က တ	ours a ral", c Exan	ğ	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates:	1994	- 1	1 □ Yes 2 ☑ No	o Opecii)	<b>/·</b>		54	pecify: Wh	ıte
5	72 ho	Completed	1 (Specify	5. Decedent's Ed only highest gra	ucation de completed)		(Give	dent's Usual Occu kind of work done	e during ma	st of working	,	16b. Kind	of Business/I	ndustry
2	vithin ine. ihan *	Id III	Elementary/Second	iary (0-12)	College (1-4or 5	+)		DO NOT use retir -CSM	ea)			II.S	. Army	
2	illed v Hygie ther i		12 17. Father's Name ( <i>Fi</i>	irst. Middle. Last)				COLI	18. Moti	her's Name (	First, Middle,			
aŭ	ould be Mental arked o	o Be	Andrew Mo						Lo	retta (	Gill			
Maryland 21215-0036	should and Men s marke umatic	၉	19a. Informant's Nam	ne/Relationship (7	ype. Print)		19b. Mailir	ng Address (Stree	et and Num	ber or Rural	Route Numb	er, City or T	own, State, Z	ip Code)
	and 2 ealth a n 27 is ier trai		Nancy L. I	McDonald	/ wife		60 I	oividing	Creel	c Cour	t Arn	old,	MD 210	12
Jre,	ss 1 a		20a. Method of Dispos		Damaual from State	20b. Plac	ce of Disponetery, crei	sition (Name of matory or other pl	ace)	April		20c. Locat	tion - City or T	Fown, State
Ĕ	Pages ment of H ant: if ite ury or of			Cremation 3 ☐ Cother (Specif)	Removal from State	MD V	etera	ans Cemet	tery	2008	′,	Crow	nsville	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fance	eral Service Licen	hrr		ノ Ba	2. Name and Add arranco & 05 Gov. I	& Sons	s. P.A	. Seve	rna Pa	ark Fu	neral Home
Н			23a Part1. Enter the	disease, or comp	plications that caused	the death.							ALIC ID	Approximate Interval Between
	Physician		Immediate Cause (Findisease of condition resulting in death)		one cause on each lir			l cell c	anc	0 1				Onset and Death
	/Medical		resulting in death)		a. Due to (or as			e cery		~				WILLOW !
	Examiner		Sequentially list cond	litions.	b									
	pe jis	ije	cause. Enter Underly Cause (Disease or in	ving	Due to or as	a consequer	nce of:							
	xecut and Il-tran	Examiner	that initiated events resulting in death) La		cDue to (or as	a conseque	nce of):							
8760,	icate be executed physician and s the burial-transit	dical E			d									
687	ificate g physis the	edic												
Box	n cert anding use a	M/u	IF FEMALE: 23b. Was decedent p	oregnant	23c. If yes, outcome 1 □Live birth			∃Ectopic pregnan	nev.			230	d. Date of deli	*
œ.	that the death certifed by the attending detached for use as	Physician/Me	in the past 12 m 1 ☐ Yes 2 ☐		4☐Pregnant at			Other (specify)					Month	Day Year
P. 0.	at the I by the	hy	9 🗆 Unknown				t Ab		-t t D	<b>.</b> (	oon Did	lahanna una	oontributa to	the cause of death?
S,	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	by	Part II. Other signific	ant conditions of	ontributing to death b	ut not resulti	ing in the u	ngenying cause g	jiven in Far	L I.				obably 4 🗹 Unknown
Š	r requ	Completed			-						24a. Was	an	24h Wara au	topsy findings available
Rec	ne law has   ge 2 s	ם									auto	psy ormed?	prior to o death?	completion of cause of
ā	in: Ti ificate or, pa		25. Was case referre	ed to medical					26. Pla	ce of Death	1□ Yes (Check only o	2 No	1 □ Yes	2□ No
Š	Physician: r this certifica ral director, I	To Be	examiner? 1 ☐ Yes 2 점 N		Hospital: 1 ☐ Inpatie	ent 2 ∐EF	R/Outpatie	nt 3□ DOA O	ther				□Other (Spec	cifv)
0	g Phy ter thi	n: T	27. Manner of Death		28a. Date of Inju (Month, Da	iry 2	8b. Time o				Bd. Describe			
Ö	Attending r death. ector: After by the fune	atio	1_Natural 2 ☐ Accident	5 ☐ Pending investigation		, ,			□Yes 2[	□No				
Division or Vital Records,	or Att after de Directe in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace of III	ury - At hom c. <i>(Specify)</i>	e, farm, st	reet, factory, offic	е	28		Street and I wn, State)	Number or Ru	ıral Route Number,
	spital				ysician: To the best									
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Medical	one)		niner: On the basis of and manner st		on and/or in		y opinion, d		at the time		lace, and due	
	vitl To	2	29b. Signature and ti	or certifier	4	$\wedge$			3603				3/3/ <i>/2</i>	
			30. Name and address	no of porson who	completed cause of	Jeath (Itam 1	(3a) /Tuno		-0-0	7			31/2	3
١	4104		B B	ERCOVIT	2 70	SOHNS	HOPK		SUTO	N HE	211	13		
8	Sta Regist	ate rar	31. Date filed (Month	NPR 0 2 2	2008 32. Brigisti	ar's Signatu	re K	porte						

DHMH 17 Rev 1/2001

			1 _ State		artment of Health and N rtificate of Death			10710
		本	Registrar  1. Decedent's Name (First, Middle, Last)	Ce	Tillicate of Death	Reg. 2. Date of Death	. No.	3. Time of Death
	Physici	an	MADISON MOORE NUTTER	)		Month	Day Year	2:12 PM
200 mm	/Medio	24 12	4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Death	Hpril	4c. County of Death	7.10
	Examin	er	CIVISTA MEDICAL C	ENTER	LA PLATA		CHARLE	ES
4	Funeral Director		0.11	Age (In yrs. last birthday)	) If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birth Month, Day, Y 2 - 16 - 1	9. Birthp	place (State or Foreign htry)
W.	and a substant of		Usual Residence of Decedent	I do on Torres				0d. Inside City Limits
	Marylar -f show fied at	tor	10a. State 10b. County  MARYLAND CHARLES	10c. City, Town or Lo	LA PLATA			1 ☐ Yes Ž∏No
	3a or 28a st be noti	I Director	10e. Street and Number 9180 CRESCENT LANE		10f. Zip Code 20646	"	. Citizen of What Cour	ntry?
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force 1 Yes, Give Year or Dates	s? ] No	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH]	etc.
21215-0036	be filed within 72 houn ital Hygiene. d other than "natural event, the Medical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king   16	b. Kind of Business/In	dustry
212	d withir glene. rr than the M	mo;	Elementary/Secondary (0-12) College (1-40	' I	SIDENT/OWNER	C	ENTER DIS	STRIBUTING
b	be filed tal Hygi d other event, tl	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	iden Surname)	
ylaı		으	IRA NUTTER			E MOORE		
Maryland	au is		19a. Informant's Name/Relationship (Type. Print) DAVID NUTTER-SON	I	ing Address (Street and Number or Ru  O VALLEY WAY HU		-	
	1 an Heal em 2 ther		20a. Method of Disposition		osition (Name of ematory or other place)		c. Location - City or To	
mor	of of fit		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	TA I	ematory or other place) EL CEMETERY 4-1	9-08 LA	PLATA, MI	) <b>.</b>
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee MOO	( / )	22. Name and Address of Facility RAYMOND FUNERAI LA PLATA, MD. 2 (		E, P.A.	
Н	4		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each				t,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease) a condition	gestive	heart full	vi		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or	a consequence of):	64			130
8		Je.	Sequentially list conditions, it any, leading to immediate	ав а сонвершение of).	Jary 110 Flan			100
	cuted nd ransit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
60,	be executed sician and burial-transit		resulting in death) Last Due to (or	as a consequence of):				
09289	physicate to physical the	dical	d					
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/Me		n 2 Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
ds, P.O.	w requires that to be been signed by should be detail	by	Part II. Other significant conditions contributing to death		underlying cause given in Part I.	23e. Did toba	cco use contribute to	
or Vital Records,	The law req te has beer age 2 shou	Completed				24a. Was an autopsy performe 1  Yes 2 J	prior to co	opsy findings available ompletion of cause of
ita	lan: ntifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)	•	
<u>r</u> <	Physician: this certificaral director, I	To E	1 Yes 2 No Hospital: 1 Inp				ce 6 □Other (Spec	ify)
o u	Ing P			Injury 28b. Time Injury		28d. Describe how	v injury occurred	
Division	a er death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building	injury - At home, farm, s , etc. <i>(Specify)</i>		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce		is of examination and/or i	ath occurred at the time, date and place investigation, in my opinion, death occ			
	ro the vithin to the ro the complex co	Med	29b. Signature and title of certifier	oldios.	29c. License number		d. Date signed (Month	
	- >F0		1531	n	D33426		4/14/0	8
			30. Name and address of person who completed cause of Larry Jenkins JR MD	of death (Item 23a) (Type	Aparle	65 LaPl	lata, MD	20646
f	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 8 2008 32. Reg	Strar's Signature	Spark			

State of Maryland / Department of Health and Mental Hygiene

	m	 0	4
100	6	6	Į

			1 - For State Registrar	State of Mar	yiaiia / L	•	ificate of			Reg. No	200	U	121	20
Г	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Dea	Da	ay Ye	ar	3. Time of	
	/Medic	al		ames O'Conn	e11		4h City Tayya a	Location of Death	April	10	200 c. County of D		2145	Рм
	Examin	er	4a. Facility Name (If not institution, given Calvert Manor He		nter		Rising			40	Cecil	realm		
le, .	Funeral		5. Social Security Number 6. S		In yrs. last bir	thday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da DEC 24,	th v. Ye <i>ar</i>		Birthpl	ace (State or	r Foreign
L	Director		043-12-2474	92		Yrs.	lworting Days	Trouis Will.	DEC 24,	191	15 (	Coni	nectic	ut
	/land ow at		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	n or Loca	ation					10	d. Inside Cit	y Limits
	a-f sh	ctor	Maryland Cecil		E1kt	ton							1 TYes	2 <b>∑</b> No
	or 28	Directo	10e. Street and Number				10f. Zip Code				itizen of Wha			
	eath w	Funeral	511 Rock Church	Road  12. Was Decedent Eve	or in II C	12 W	21921		posify Voc or No		Jnited  14. Race - A			
0	ifter de ir item		11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	iii 0.3.			ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, V			
2-003p	ours a iral", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		11	∐Yes 2 <b>X</b> No	Specify:			Specify:	Whi	te	
ה	ר 72 ה "natu edical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decede	nt's Usual Occup	ation during most of work f)	king	16b. k	Kind of Busine	ess/Ind	ustry	
7	withir iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			ticultu:			F	Private	e Es	state	
2	al Hyg other	BeC	17. Father's Name (First, Middle, Last	)	'			18. Mother's Nam	e (First, Middle,	Maidei	n Surname)			
yland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. . marked other than "natural", or items 23a or 28a-f show mattc event, the Medical Examiner must be notified at	To E	Daniel O'Connell					Annie K						
Ma	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship ( Edward James 0'(			_		and Number or Ru ch Road,		-			<sup>Code)</sup> 1921	
	f Heal f Heal frem 2		20a. Method of Disposition				tion (Name of atory or other place	i	Date		ocation - City			
Ē	Page nent o int: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Speci</i>	THemoval from State			Cemeter	, npi	1 17,	New	v Canaa	an.	СТ	
pallimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Menth Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee		Hi Hi	Name and Addre	ss of Facility for Fund ockton St	erals. I					
	AO E R O		23a. Part1. Enter the disease, or com	. Hecks	a death Da						on, MD	_21	921	
	Dhaminian		shock, or heart failure. List only	one cause on each line.	100			Λ					Approximate Interval Bet Onset and D	veen )eath
	Physician /Medical		disease or condition resulting in death)	a. Chron	onsequence	of):	Truction	e l'ulm	ovary	OI.	suase	-	year	`5
	Examiner		Sequentially list conditions.	U.	cco	Ab.	use						Years	>
	ted sit	Examiner	Sequentially fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence	of):							*	
Ś	execu n and ial-trar	Exar	that initiated events resulting in death) Last	cDue to (or as a c	onsequence	of):								
00/00,	rificate be executed ng physician and as the burial-transit	ledical		<b>_</b> d										
_	ertifica ling ph e as th		IF FEMALE:	00- 15										
20	attend for us	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2 { 4 ☐ Pregnant at tin	Fetal death		ctopic pregnancy Other (specify)	/			23d. Date of Month			'ear
į	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			(-,,, -,, -,, -,, -,, -,, -,, -,, -,, -							
r n	w requires that the death cer been signed by the attendin should be detached for use	by P	Part II. Other significant conditions		•			en in Part I.	23e. Did to	obacco	use contribu			
cords,	requir een si nould	ted	Congestiv	e Cardi	smy o	pat	ny		720	Yes 2	2 No 3	] Proba	ably 4 ⊡U	nknown
ב ט	2 5 2	Completed							24a. Was autor		24b. Wer prior deat	to con	osy findings a npletion of ca	available ause of
N II G	an: The	e Co	25. Was case referred to medical					26. Place of Dear	1□ Yes	200N	lo 1 🗆		2 <b>Q</b> No	
>	nysicia lis ceri direct	To B	examiner? 1 ☐ Yes 2 <b>₹</b> □No	Hospital: 1 ☐ Inpatient	2 ER/Ou	ıtpatient	3 □ DOA Oth	or: .	ome 5 ☐ Resi		6 □Other (	Specify	')	
5	ing Pt Affer th uneral		27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Y		Time of Injury	28c. Injur Wor		28d. Describe I	how inju	ury occurred			
200	ttend death. ctor: / the fi	icati	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Diago of injury	- At home, fa	ırm stree		Yes 2 □ No	28f. Location (S	Street a	and Number	r Bura	I Route Num	hor
2	al or A s after I Directed in by	Certification:	4 ☐ Homicide determined	building, etc. (	Specify)	, 0	n, ractory, onloc		City or Tox	wn, Stat	te)	nnunai	modie radiii	<i>Jet</i> ,
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. Within 24 hours after death. To the Luneral Directors After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 Check only 2 Medical Exa	nysician: To the best of r miner: On the basis of ex	ny knowledge	e, death	occurred at the tirestination in my c	me, date and place	, and due to the	cause(s	s) and manne	er as st	ated.	
	the F	Medical	one) 29b. Signature and title of certifier	and manner state	d.		29c. Licens		Too at the time,					,
	5 ¥ 5 8	-	O O S 7	la				58354		250. D	ate signed (N		zay, rear)	
			30. Name and address of person who	completed cause of deat	th (item 23a) (	(Type, P					. (all)	J		
			WEIL E. LATTIN.	W.D 10		DIPLE	IL Wa	y Risi	ng Sun	W	10 g	191	1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature				_					

DHMH 17 Rev 1/2001

Registrar

APR 1 8 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Mary Gage Purves April 2008 8:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11612 Michale Court Montgomery Silver Spring If Under Hours Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 577 70 1113 99 Director Aug. 6, 1908 Montana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 11612 Michale Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Garrison Gage Edna Ryman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Purves/Son 11612 Michale Court Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Crematory 4/06/2008 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. W. Anthony Murray 5130 Wisconsin Ave., NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease Dementia vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔯 No 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0038781 04/02/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4201 Cathedral Ave., NW #114W Washington, DC Michael J. Grady MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR-03 2008 Registrar

DHMH 17 Rev 1/2001

			1 - State Registra AMEND#8, per	State of Ma $^{ m FH}$ , $4/14/08$ ,	ryland DPS,	d / Depa Moc <i>6er</i>	ırtment of ⊢ <i>tificate of i</i>	lealth and N Death		giene Reg. No.	2008	12722
۱	Physici	an	1. Decedent's Name (First, Middle, La Blossom A. Rit	431)					2. Date of De March		2008 <sup>Year</sup>	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, gi	ve street and number)				Location of Death	J	4c. (	County of Death	
		.5%*	8100 Connecticut  5. Social Security Number 6.			as <i>t birthd</i> ay)	Chevy Cl		8. Date of Birl		Montgome 720 9 Birth	-
	Funeral Director		043-07-6410	1□M 2∏F	87	Yrs.	Months Days	Hours Min.	Decemb	e Year 18 1920	Nev	place (State or Foreign ntry) V York
	yland at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	he Mar 28a-f sl otlfied	Director		gomery	C	hevy	Chase			10- Ciai-	an of Mhat Cou	1X Yes 2 No
	th with 1 23a or 3 st be n	al Dir	10e. Street and Number 8100 Connecticut	Avenue #61	1		10f. Zip Code 208	15		_	en of What Cou ited Sta	
336	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1	Vas Decedent of H f Yes, specify Cuba □ Yes 2√2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ameri Black, White Specify: Wh	etc.
1215-0036	"natur	leted	15. Decedent's E (Specify only highest gi	ducation rade completed)	I	16a. Deced	lent's Usual Occup	ation during most of work d)	king	16b. Kin	d of Business/Ir	ndustry
	d withir giene. er than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)		Homemake:			(	Own Home	2
and	l be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	·	, Maiden S	Surname)	
aryii	should and Me s mark umatic	J.	Aron Agrin 19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	Rose Ca and Number or Ru		er, City or	Town, State, Zi	p Code)
e, Z	1 and 2 Health em 27 i	1 5	Loren Kantor - 1 20a. Method of Disposition	Daughter	20b. Pl			y Court N	W Washi		n DC 200	
Baltimore, Maryland 2	permit. Pages. Department of I Important: If its any injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ify)	Ju	dean M	sition (Name of natory or other plac emorial (	Grdns 3/	28/09		y, MD	own, out
g	Depa Impo any ii	Į. Į	21. Signature of Funeral Service Lice	ensee	-		Name and Addre	el Funera kville Pi	l Direc ke Rock	tion	e <sup>I</sup> MB 208	352
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)				er the mode of dyir		or respiratory a	rrest,		Approximate Interval Between Onset and Death Months
	/Medical Examiner			Due to (or as a	consequ	ence of):						
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Linter Uniterlying Cause (Disease or injury	Due to (or as a	consequ	ence of):						
oʻ	execut an and rial-trar	Examine	that initiated events resulting in death) Last	c Due to (or as a	consequ	ence of):				·		
08/60	ificate be executed g physician and as the burial-transit	edical		d,								
C. Box	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	1		2	3d. Date of deliv	very Day Year
<u>х,</u>	w requires that the d been signed by the should be detached	by Pł	Part II. Other significant conditions	contributing to death bu	t not resu	Iting in the ur	nderlying cause giv	en in Part I.				the cause of death?
Sord	law requii as been s 2 should	leted							1 ☐ `			bably 4 □Unknown opsy findings available
vital Records,	The ate h	Completed							auto		prior to co death? 1 □ Yes	ompletion of cause of
	certific rector,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	· 0 🗆	ER/Outpatien	+ 3CLDOA Oth	26. Place of Dea			<b>Tau</b> (2	
n or	ding Phys n. After this funeral dii	<del>-</del>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y	28b. Time of Injury	, oll box	4 Li Nursing H	28d. Describe		Other (Special occurred)	ity)
UIVISION	r Attending Pher death. Irector: After the by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide determined	De 28a Place of injur				Yes 2 No	28f. Location (S			ral Route Number,
2	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Cer	(Check only 2 Medical Exa	hysician: To the best o	f my knov examinat	vledge, death	n occurred at the tir	me, date and place	, and due to the	cause(s)	and manner as	stated. to the cause(s)
	<b>Го the</b> within 2 го the сотрет	Med	29b. Signature and title of certifier	and manner stat	ted.		29c. Licens				signed (Month	
)	10		· /w				D3346	4		Mar	ch 27, 2	2008
			30. Name and address of person who David M. Hansen					Suite 347	Washin	gton	DC 200	16
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2	32 Registra	r's Signat		uli)					

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if Item 27 is marked other then "netural", or Items 23s or 28s-f show ir then "netural", or iteme 23a or 28a-f ehov the Madical Examinar must be notified at Completed by Funeral Director Baltimore, Maryland 21215-0036 traumatic event, 17. Father's Name (First, Middle, Last) Be ဨ 19a. Informant's Name/Relationship (Type, Print) Sheila G. Rickman-Wife other 20a. Method of Disposition ö permit. Page Department of Important: If any injury or once. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that pitieted events.) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit end that initiated events resulting in death) Last attending physicien for use as the buria Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy, Coronary Artery Disease, Diabetes Mellitis Type II, End-Stage Renal Disease certificate After this certifical funeral director, p 25. Was case referred to medical examiner? 27. Manner of Death s effer dea. filled in by To the Hospital within 24 hours e To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23958 April 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 N. Leisure World Blvd. Burt Feldman, MD 31. Date filed (Month, Day, Year) APR 0 3

Silver Spring, MD 20906

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🧲 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year O 8 Month 3 **Physician** 720 M NN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🔀 F 68 New York 053-32-5733 Director Oct. 14, 1940 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Gambrills 1 ☐ Yes 2 → No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21054 USA 2605 Chapel Lake Drive Condo 302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CareFirst permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant BlueCross BlueShield 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle E. Dewire Edwin W. Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14663 Triadelphia Road Glenelg, MD 21737 Cheryl Myers/ friend March 31, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Metro Crematory Baltimore, Maryland 2008 21. Signature of Function Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** WK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, that y localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 D No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3□ DOA 1 🕱 Inpatient 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

or Vital Records, P.O. Box 68760,

Baltimore,

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

no completed cause of death (Item 23a) (Type, Print)

APR 0 2 2008

32. Resstrar's Signature

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 April **Physician** Ronald Denis Schmidt 11 11:13 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6814 Falstone Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1/X M 2 □ F 495-36-2521 72 March 18, 1936 Missouri Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d Inside City Limits Examiner must be notified at Mary land Frederick Frederick Director 1 □Yes 2X No - 28a-f 10e. Street and Number 10f. Zin Code 10a. Citizen of What Country? 23a or 21702 United States 6814 Falstone Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 0 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or Items 11 Marital Status 1 X Yes 2 No 1954 − If Yes, Give Year or Dates: 1962 Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hyglen. Important: If item 27 is marked other tha any injury or other traumating. Graphic Designer Frederick Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rex Gary Schmidt Frances L. Bates ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Schmidt / Wife 6814 Falstone Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 12, 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 Fast Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death ADENO CARSINOMA OF THE LUNG Immediate Cause (Final **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cras a not sequence of) Examiner be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? certificate 2 No 2□ No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as oracle.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

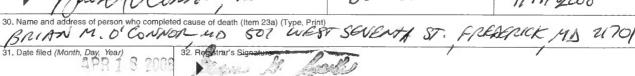
> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

29a. Certifier



29c. License number 0 31 76/

29d. Date signed (Month, Day, Year)

		For State Registrar	State of Ma	-	epartment of F Certificate of		nemai ⊓yy R∈	eg. No. 200	8 12726
Physici	an	1. Decedent's Name (First, Middle, Las		- l- 1			2. Date of Deat Month April		3. Time of Death
/Media	cal	Peggy Lov  4a. Facility Name (If not institution, give		chlee	4h City Town o	r Location of Death		4c. County of De	
Examin	ier	Northampton Manor		ome		ederick			derick
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birtl	hday) If Under 1 Year		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Director		220-05-7770 Usual Residence of Decedent	□M 2QF	87 Y	rs. Months Buye		Apr. 4,		Maryland
land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Many a-f sh	ţō	Maryland Carro	011		Westm	inster			1 XYes 2 No
iff the or 28	Director	10e. Street and Number	•		10f. Zip Code		10	0g. Citizen of What	-
s 23a	rall	225 Frock Dr			10 Man Danadani of I	21157	if- Van av Na		S.A. merican Indian,
ter de items	Funeral I	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉 No		<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	an, Mexican, Puerto	Rican, etc.)	Black, W	
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify: W	/hite
72 ho 72 ho 'natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. l	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of work	king	16b. Kind of Busine	ess/Industry
within sne.	ldm	Elementary/Secondary (0-12)	College (1-4or 5+	•)	postal w			Federal	government
filed Hygin Sther ent, ti	Be Co	17. Father's Name (First, Middle, Last)			posta: w	r	e (First, Middle, M		<u> </u>
uld be Aental rked c	To B	William D. Lo	vell Jr.			Gold	lie E. Mc	Clelland	
2 short and his ma		19a. Informant's Name/Relationship (			Mailing Address (Street				
and lealth mm 27		G. Michael Schlee	/ son		2 Pendleto			a, VA 223	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Managone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			Disposition (Name of y, crematory or other pla	1		•	
nit. Pa artme ortant injury		4 □ Donation 5 □ Other (Specification of Funeral Service Licer		ATT COU	nty Cremati 22. Name and Addre			Sykesville uneral Ho	
permit. Departm Importa any inju		atharine (	). Hartel	er	310Church	St. Ne	ew Windso	or, MD 21	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a. Fai	luve	to This	le .			RONTHS
/Medical Examiner		resulting in death)	Due to (or as a	consequence o	n: W/AS				MONTHS
8	e.	Sequentially list conditions,	b. Due to (or as a	consequence o					CHIMON
cuted	amin	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
e exe kian ar urial-t	EX	resulting in death) Last	Due to (or as a	consequence o	f):				
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner		d						
certiff nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		_			23d. Date of	delivery
death e attel	Physician/N	in the past 12 menths? 1 ☐ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at t		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y ————————————————————————————————————		Month	Day Year
at the by the stache	hys	9 ☐ Unknown	9□Unknown				00 5:1:1		
ires th	þ	Part II. Other significant conditions of	~_	LULAT		ven in Part I.	23e. Did tot		e to the cause of death?  Probably 4 Unknown
v requ	eted		1 (1)				24a. Was a		autopsy findings available
he lav e has age 2	Completed						autops perforr	sy prior death	to completion of cause of h?
an: T tifficati tor, pa	Be Co	25. Was case referred to medical				26. Place of Dea	th (Check only on		Yes 2□No
nysici	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatier	nt 2 ER/Out	patient 3 DOA Oth	ner: 4 Nursing H	ome 5 Reside	ence 6 Other (S	Specify)
Attending Physician: The law redorath.  ector: After this certificate has by the funeral director, page 2 s		27. Man or of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y 28b. T Year) Ir	ijury Wo		28d. Describe ho	ow injury occurred	
ttend death. ctor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		rv - At home. far	M	]Yes 2□No	28f. Location (St	treet and Number o	r Rural Route Number,
all or A	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,		City or Town		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ospita hours unera ily fille					, death occurred at the t				
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	one)	and manner stat						
To with	2	29b. Signature and title of certific			29c. Licen:		,   2	9d. Date signed (M	P
,		30 Name and address of person who	completed cause of de	ath (Item 23a)	Type, Priet)	-		1/00/01	
		30 Name and address of person who	LATUM,	rep, to	16 TJ Dei	UE, FR	C0521C	E, MD-	21702
Sta Regist		31. Date filed (Month, Day, Year)  APR 1 8 20	Szakegistia	r's Signature	Local 1				
negisti	· ul	AND I V A	1000000	1 155	A CONTRACT				

			For State of Marylan  1- State Registrar		rtment of He		, ,	200	0 12727	P
			Registrar  1. Decedent's Name (First, Middle, Last)		incate of B		Date of Dea	eg. No	3. Time of Death	_
	Physici		Rose Skolnick			M	Month arch 2		1:55 P <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		arch 2	4c. County of [		-
		Ŭ.	The Casey House		Rockvi	.11e		Montgo	omery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 1 □ M 2 🖾 F		If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day	, Year) g.	Birthplace (State or Foreign Country)	
	Director		137-36-0422	Yrs.		M	ay 8,	1913 I	Poland	_
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Loc	cation			<u> </u>	10d. Inside City Limits	-
	Maryl. f sho ied al	ō	Montecomony	C = 1 c	r Spring				1 ⊠Yes 2 □ No	
	the 1 28a- notif	Director	MD Montgomery  10e. Street and Number	211/6	10f. Zip Code		1	0g. Citizen of Wha	at Country?	-
	3a or	<u>=</u>	17234 New Hampshire Avenue		20905			U.S.A.		
	be illed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13. V		panic Origin? (Specif , Mexican, Puerto Ric		14. Race - /	American Indian, White, etc.	_
و	after or ite mine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes. Give			Specify:	Jun, 010.j	C!f !!		
51215-0036	ural",	d by	3⊠Widowed 4 □ Divorced Year or Dates:	1 10 0			-		White	_
7	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupat kind of work done du OO NOT use retired)	ion Iring most of working		16b. Kind of Busin	ess/Industry	
7	withir ene. than he Me	E C	Elementary/Secondary (0-12) College (1-4or 5+)	Homem				Own H	Home	
7. 0	filed within 72 h Hygiene. other than "natu ent, the Medical		17. Father's Name (First, Middle, Last)	Homen		18. Mother's Name (F	irst, Middle,	<del></del>	101110	_
Maryland	es 1 and 2 should be of Health and Mental Item 27 is marked or other traumatic ever	To Be	Sam Fisher			Ida	"Unkno	wn''		
aZ	should and Men marke umatic		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street ar	nd Number or Rural F	Route Numbe	r, City or Town, Sta	ate, Zip Code)	_
	and 2 ealth a n 27 Is		Shelton Skolnick - Son	1304	Dale Driv	e Silver	Spring	g, MD 209	10	
Baltimore,	ges 1 at of He If Item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	Place of Dispos cemetery, cren	sition (Name of natory or other place,	Date)	е	20c. Location - Cit	y or Town, State	
Ĕ	permit. Pages Department of I Important: If Its any Injury or o			11ywood	Mem. Par	k 4/7/2	800	Hollywood	d, Florida	
ğ	ermit. epart nport ny Inj		21. Signature of Funeral Service Licensee	Ed.	Name and Address ward Sage.	of Facility L Funeral	Direct	ion, Inc	•	
_	⊕ <b>© = @ o</b>					lle Pike				
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ente	er the mode of dying.	, such as cardiac or r	espiratory ari	est,	Approximate Interval Between Onset and Death	
١.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Recurrent I		iia					_
	Examiner		Due to (or as a consequence of the control of the c	uence of):						
2	- 1	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).	uence of):						-
	uted J ansit	Examiner	Cause (Disease or injury that initiated events c							
o,	exec an and rial-tra		resulting in death) Last Due to (or as a consequence of the consequenc	uence of):						_
8/60,	cate be executed physician and the burial-transit	dical	d							_
9		Med	IF FEMALE:							
XOR	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	al death 3	Ectopic pregnancy			23d. Date of	,	
	0 0	sici	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of d 9 ☐ Unknown 9 ☐ Unknown	ieath 5□	Other (specify)			Month	, buy . bu	
1	The law requires that the de ate has been signed by the a bage 2 should be detached i		Part II. Other significant conditions contributing to death but not resi	ulting in the ur	iderlying cause giver	n in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?	_
Vital Records,	signe d be	d by	Dementia	J	, , ,		1 □ Y	′es 2∐No 3[	☐ Probably 4 X Unknown	
် ဂ	w require been si should t	Completed	Conserved Halance Budances				24a. Was a	an 24h Wo	re autopsy findings available	_
ž	The law	dm	Cancer of Unknown Primary				autop perfor	sy prio med? dea	or to completion of cause of ath?	
©			25. Was case referred to medical			26. Place of Death (			]Yes 2□No	_
	Physician: r this certific ral director, I	o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	l ER/Outpatien	Othor	,			(Specify)Hospice	
Division or	g Physier this eral dir	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury				ow injury occurred	· · · · · · · · · · · · · · · · · · ·	_
Ö	ath. or: After ne funera	atio	2 Accident investigation	injury		es 2 □ No				
<u> </u>	r Atte er de recte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office	28	f. Location (S City or Tow	treet and Number ( n, State)	or Rural Route Number,	
	ital o irs aft iral Di									_
	To the Hospital or Attending Planthing 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral process.	Medical	29a. Certifler    X Certifying Physician: To the best of my kno (Check only 2   Medical Examiner: On the basis of examine one)							
	thin 2 thin 2 the ample	Med	one) and pranner stated.  29b. Signature and title of certifier		29c. License	number	- 2	29d. Date signed (/	Month, Dav. Year)	_
	F > F 8		Dog Willellon. dech							
,	5		30. Name and address of person who completed cause of death (Iten	n 23a) (Tyne	D6461			March 30,	, 2008	_
			Genevieve Anne Wroblewski, MD			rive Rock	ville.	MD 20850	)	
2	Sta	ite	00 10 11 12 12	-1			,			
	Registr	ar	APR 0 3 2008	13. P.						

				Plea	se Type or F					Ensure A	-		_egible.		
			for State Registrar		State of	iviaiyi		ertifica:			wentai i i	Reg. No.	200	R 19	729
	Discrete!		1. Decedent's Nar	me (First, Middi	le, Last)						2. Date of D		Year	3. Time	of Death
	Physici /Medic		LAUF			INGMAI	N				MARCH	26, 2	800	2:30	P M
	Examir	er			n, give street and num	nber)		4b. City		Location of Deat	h	4c.	County of De	ath GOMERY	
-	Funeral		5. Social Security	SHTON GA Number		7. Age (In y	rs. last birthda		r 1 Year	If Under 24 Hrs	8. Date of B	irth		irthplace (State	or Foreign
н	Director		577-09 <b>-</b> 00	)45	1 ☐ M 2 🔀 F		93 Yrs.	Months	Days	Hours Min.	01/15/	ay, Year) 1915	MA	RYLAND	
	and w		Usual Residence	of Decedent 10b. County		10c.	City, Town or	Location						10d. Inside	City Limits
	Maryla f sho led at	jo	MARYLAND	MONTGO		]	BETHESE	A							s 2 No
	r 28a-	Director	10e. Street and N	umber				10f. Zi	p Code			10g. Citi:	zen of What C	Country?	
	th with		5550 TUCK	CERMAN 1	LANE			20	852			USA			
	er dea tems er mu	Funeral	11. Marital Status		12. Was Dece Armed For	ces?	n U.S. 1:	3. Was Dece If Yes, spe	edent of H ecify Cuba	Ispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	10-	<ol> <li>Race - An Black, Wh</li> </ol>	nerican Indian, nite, etc.	
36	flied within 72 hours after death with the Maryland Hygiene. uther than "natural"; or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F		rried 2 ☐ Mar 4 ☐ Divorced	If Yes Giv	e		1 ☐ Yes	2XI No	Specify:			Specify: W	HITE	
9-00	"2 hou natura ical E	ted	(Cn:	15. Deceder	nt's Education est grade completed)		16a. De	cedent's Usu	al Occup	ation during most of wo	rkina	16b. Ki	nd of Busines	s/Industry	
21215-0036	ithin 7 ne. nan "r Med	Completed	Elementary/Sec		College (1	-4or 5+)	life	. DO NOT i	ise retired	1) -	iknig		D	**	
121	iled w Hygiei ther th		17. Father's Name		Last)			SALES	PERS	ON 18. Mother's Na	me (First Midd	e. Maiden	RETAI	L	
land	id be f ental I ked of	To Be	LOUIS FRA						]	DORA LEV	•	,			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. It health a say a cr 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۲	19a. Informant's		ship (Type. Print)					and Number or R					
	1 and 2 Health a em 27 is		BERYL FIS	SHMAN,	DAUGHTER					AVE, #9					20814
ore	ges 1 t of H if iter or oth		20a. Method of Di		3 Removal from S	State	b. Place of Dis cemetery, c	rematory or	other plac		Date			or Town, State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 ☐ Donation 21. Signature of F	5 Other (5	Specify)	K				DNS 03/3				CH, VII	KGINIA
Ba	permi Depar Impor any ir		Done	ald (	2 / 1	tem	rus I	DWARD	SAG	ss of Facility EL FUNER ILLE PIK	AL DIRE	CTION	, INC.	TAND 2	20852
			23a. Part1. Enter	the disease, o	r complications that ca t only one cause on ea								10-27-20-2	Approxim Interval B	ate
J	Physician		Immediate Cause disease or condit	e (Final ion	_a. CARDI									Onset an	d Death
1	/Medical Examiner		resulting in death	)			sequence of):		-						
		0	Sequentially list of	conditions,	D.		AORTIC	ANEUR	YSM					-	
	uted d ansit	Examiner	if any, leading to cause. Enter Und Cause (Disease of that initiated even	or injury			EROTIC	HEART	DIS	EASE					
o,	executed an and rial-transit	Exa	resulting in death				sequence of):								
9289	ficate be of physicial is the buri	Jical			d. HYPER	TENSI	ON							-	
9 X	death certificate be attending physicis for use as the bu	Physician/Medical	IF FEMALE:		23c. If yes, outo	come of ore	egnancy						and Data of a	lalli sami	
Вох	ath atter	cian	23b. Was decede in the past 1 1 \(\sum \) Yes 2	2 months?	1 ☐ Live b	irth 2 F ant at time	etal death	3 □Ectopic p 5 □ Other (s		1		1	23d. Date of o Month	Day	Y <i>e</i> ar
Ö	t the c by the achec	hysi	9 Unknow		9□Unkno	wn						i			
s, P.	w requires that the sbeen signed by the should be detached	by P		nificant conditi	ions contributing to de	ath but not	resulting in the	underlying	cause giv	en in Part I.				to the cause of	
ord	requir een si nould I		DEMENTIA								1	Yes 24	_ No 3	Probably 4 [	Unknown
3ec	e law has b je 2 si	Completed										opsy	prior t	autopsy finding o completion o	s available cause of
or Vital Records,	ate Th	_	25 Mag acces :-	arrad to madi-						00 51 15	1□ Yes		death 1 ☐ Y	es 2□No	
. Vit	Physician: this certific	o Be	25. Was case referenced examiner?		Hospital:	npatient 2	2 ☐ ER/Outpat	ient 3□□	OA Oth	er: 4 X Nursing	ath <i>(Check onl</i> ) Home 5□Re		6 FlOther (9)	necify)	
		n: To	27. Manner of De	ath	28a. Date o		28b. Time		28c. Injur Wor		28d. Describ			,cony)	
vision	Attending or death. ector: After by the fune	ification:	1 X Natural 2 ☐ Accident		igation			M	1 🗆	Yes 2 □ No					
Š	Att de ct by t	Ιξί	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	nined 28e. Place	of injury - A	At home, farm,	street, facto	ry, office		28f. Location	(Street an	d Number or	Rural Route N	umber,

Division or Vital Records, P.O. Box 68760, To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by Medical Cert

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

29c. License number 29d. Date signed (Month, Day, Year)

D53691

MARCH 27, 2008

30. Name and addless of peron who completed cause of death (Item 23a) (Type, Print)

DR AJAY REDDY, 6320 DEMOCRACY BLVD, BETHESDA, MARYLAND 20817 31. Date filed (Month, Day, Year)

State Registrar

03 2008



			For State AMEND#22- DH 1	State of Mary						6	008	12729
			- State RegistAMEND#23a, Pt.1, ]  1. Decedent's Name (First, Middle, La.)		HS,MOUBL	erinicai	e or De		2. Date of Dea	Reg. No.		3. Time of Death
	Physici		Dorcas G. Simms	,				1_	Month March	30	Year 2008	7:29 AM
100	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or Loc	ation of Death		1	ounty of Deat	
			Prince Georges Co	ommunity Hos	pital	Che	verly			Pri	ince G	eorges
	Funeral		Social Security Number     6. S     1	□M oXT =	yrs. last birtho	Months		ours Min.	8. Date of Birtl (Month, Day	r, Year)	9. Birt Co	thplace (State or Foreign buntry)
	Director		578-58-9924 Usual Residence of Decedent	87	Yrs	S.			Jan. 11	,1921	l Sou	th Carolina
	yland Now		10a. State 10b. County	10	c. City, Town o	or Location						10d. Inside City Limits
	Mar.	ţċ	DC None	W	ashingt	ton						1 XYes 2 No
	th the	lrec	10e. Street and Number			10f. Zip	Code			10g. Citize	on of What Co	ountry?
	23a	rai	700 7th Street, So			5 20	024			USA		
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, It e Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S.	13. Was Dece If Yes, spen 1 ☐ Yes		nic Origin? (Spec exican, Puerto P pecify:	ofy Yes or No- lican, etc.)		Black, White Black, Black, White Black, White Black, White Black,	e, etc.
2-0	72 ho	eted	15. Decedent's Ec (Specify only highest gra	fucation de completed)	16a. De	ecedent's Usua	al Occupation	a most of workin	a	16b. Kind	of Business/	/Industry
121	vithin ne. hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				g most of workin		77 . 1	1.0	
і Б	filed v Hygie thert		17. Father's Name (First, Middle, Last)	4	Exe	cutive		istrator Mother's Name				vernment
Maryland	d be Bental Ked o	To Be	Murray C. Gass							maiden St	211101110)	
37	shoul nd M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. M	lailing Address	S (Street and A	ssie Yo Number or Rural	ung Route Numbe	r, City or T	Town, State, 2	Zip Code)
ž	and 2 alth a 127 io		Jason Hightower/G	randson	300	M Stre	et, So	uth West	t Washi	netor	n, DC	20023
altimore,	of He of He fiterr		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Di cemetery,	isposition (Nar crematory or o	me of other place)		ate		ation - City or	
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify	i tomovar morn otato		ton Na	tional	April	4,2008	Sui	tland	Maryland
Ball	ermit Depart nport ny inj		21. Signature of Funeral Service Licen	500				100000000000000000000000000000000000000				ice, Inc.
	70 = 0		Chore .	Monpae	1-11- 2			Avenue,			gton,D(	
н			23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	one cause on each line.	death. Do not	enter the mod	ie of dying, su	ich as cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Acute Myo Due to (or as a co			ction					
	Examiner			b. Congestiv	, ,		ra					
		ner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	rallu.	. C					
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	<sub>c</sub> Fluid Re								
, 0,	oe exe cien a urial-		resulting in death) Last	Due to (or as a co								
68760,	ficate be executed physicien and is the burial-transit	edical		d Renal Fa	llure							
Вох	The law requires that the death certifole has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp				230	d. Date of del Month	ivery Day Year
<u>Р</u> О	that the solution of the solut	Ph	Part II. Other significant conditions o	ontributing to death but no	at resulting in th	ne underlying c	ause given in	Part I	23e. Did to	hacco use	contribute to	the cause of death?
ords,	w requires to been signer should be	5							1 🗆 Y	es 2 <b>[</b> ₹]	No 3∏Pr	robably 4 □Unknown
Division of Vital Records,	n: The law ficete hes r, page 2 t	e Completed	25. Was case referred to medical							sy med? 2 ⊈No	prior to death?	atopsy findings available completion of cause of
₹	s cert	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	218 ER/Outpa	atient 3 □ DC	Other	Place of Death  Nursing Hom			7000 (6	- 6.1
٥	Attending Physicien: r death. ector; After this certifice by the funeral director, p		27. Manner of Death	28a. Date of Injury (Month, Day Ye.	28b. Tim		28c. Injury at Work?		8d. Describe h			city)
<u>ö</u>	andin ath. or; Af	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Inju	M	1 ☐ Yes	2 □ No				
<u>N</u>	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, pecify)	, street, factory	, office	28	Bf. Location (S City or Tow		Vumber or Ru	ural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  Yo the Funeral Director; After this certificete hes completely filled in by the funeral director, page 2	Medical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of mainer: On the basis of exa and manner stated.	/ knowledge, d mination and/o	eath occurred ir investigation	at the time, da , in my opinior	ate and place, ar n, death occurred	nd due to the c d at the time, d	ause(s) ar late and pl	nd manner as lace, and due	s stated. to the cause(s)
	To t	2	29b. Signature and title of certifier	20-		290	. License nun	nber	2	29d. Date s	signed (Monti	h, Day, Year)
	5		quela	Lat)			1273	77		03/	1311	08
			30. Name and address of person who of Ophnell Cumberbat				ve. Ch	everly,	Marvlan	/ d 207	785	- 40
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's		A DII	, c, one		y	201		
	Registr		APR 0 3 20	108 Decues	J. A	books	•					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2008 ear **Physician** 1 5:30 A M John Walter Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester 10009 Pitts Rd. Showell If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) MD 5. Social Security Number 8. Date of Birth Month, Day, Year 7/27/1936 7. Age (In yrs. last birthday **Funeral** 1 M 2 □ F 71 217-30-8108 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 ☑ No Director MD Worcester Showell 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a 10009 Pitts Rd. 21862 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natura , the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Litter Truck **Poultry** permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event; it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Preston Smith Wilsie Layton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Smith / wife 10009 Pitts Rd., SHowell, MD 21862 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Cape Henlopen Crem. 4/2/2008 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 090 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner burial-transit pe

show

within 72 hours after death

12 should be filed w h and Mental Hygie. 7 Is marked other ti

Baltimore, Maryland 21215-0036

Box 68760,

P.O. |

Division or Vital Records,

this certificate

To the Hospital within 24 hours at To the Funeral D

BA 3

signed by the attending physician d be detached for use as the buria cate has been s page 2 should Certification: To al or Atter...
urs after death.
.teral Director: After thi
ity filled in by the funer?

25. Was case referred to medical examiner?	L
examiner? 1 ☐ Yes 2 ☎ No	
27. Manner of Death	
1 Natural 5 Pending investigation	
2 Accident investigation	on

28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28c. Injury at Work?

Just 302

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

4 Homicide 29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

40053717

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mate NO

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 0 4 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	St	ate of N	<i>l</i> laryland	•	artment rtificate				lental Hy	giene Reg. No.	008	12731
			1. Decedent's Name (First, Mid	dle, Last)								2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		DOLLIE	ROXDE	NE S	STOUT						April	7	2008	5:45a <sup>™</sup>
	Examir	er	4a. Facility Name (If not instituti			r)				Location of	of Death			County of Death	
			Dennett Roa  5. Social Security Number	d Man		Age (In yrs. la.s	e biethelo d	Oak		d If Under	24 Hrs	9 Date of Bir		Garrett	
1	Funeral Director		235-20-5903	1 M		96	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 6 / 6 / 1	y, Year) 911	WV	place (State or Foreign ntry)
			Usual Residence of Decedent	<u> </u>	L							0/0/1			
	how		10a. State 10b. Coun	•		10c. City, 1									10d. Inside City Limits 1   Yes 2   No
	Ba-f	Director		rett		Oak	land								
	within 72 hours efter deeth with the Marylend ane. than "natural", or Items 23a or 28a-f ahow is Medisal Examinar must be collitied at	훕	10e. Street and Number 1113 Mary I	rive				10f. Zip	550				-	zen of What Cou	ntry ?
	leeth me 23	Funeral	11. Marital Status	12. V	Vas Deceder	nt Ever in U.S.	13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No		14. Race - Ameri	cen Indian,
S	or Iter		1 ☐ Never Married 2 ☐ Ma	rried 1	rmed Forces ☐Yes 25			It Yes, spec	ity Cuba	n, Mexicar	, Puerto	Rican, etc.)	1	Black, White	
93	ours efter iral', or its Exemin	d by	3 Widowed 4 □ Divorce	d Y	Yes, Give Year or Dates	s:		1□ Yes 2	SX1 NO	Specify:				Specify: Whi	.te
5-0	"natu	Completed	15. Decede (Specify only high	ent's Education est grade con		1	(Give	dent's Usua kind of wor DO NOT us	k done d	during mos	t of work	ing	16b. Kir	nd of Business/Ir	ndustry
12	within than	ш	Elementary/Secondary (0-12) 8th	C	college (1-4o	r 5+)		lurse						Health	1
<b>d</b> 2	be filed with tal Hygiene. d other then event, the M		17. Father's Name (First, Middle	, Last)				urse	5		er's Name	e (First, Middle,	Maiden		1
an	id be iental ked c	To Be	John Abels							Iv	у Е	ckles	Abe]	ls	
Maryland 21215-0036	is 1 and 2 should be filed vol Heelih end Mental Hygie item 27 is marked other? other traumatic event.		19a. Informant's Name/Relation	nship <i>(Type, F</i>	Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	er, City or	Town, State, Zi	o Code)
	2 ≥ 2 = 2		Linda E. F	oling	<u> </u>					Stre		Kingw			26537
Baitimore,			20a. Method of Disposition 1☑ Burial 2 ☐ Cremation	3 □Remo	val from Stat	cem	etery, crei	sition (Nam natory or ot	ther plac			Date		cation - City or T	
Ë	Pag tment tent:		`4 Donation 5 □ Other	Specify)		Fai						0/2008	Bru	aceton	Mills,WV
Bail	permit. Page Depertment Importent: I any injury o		21. Signature of Funeral Service  Kathurus	, Vu	riter		C	R 5	R. Box	Spea	r Fu Bru	uneral ceton	$ exttt{Mil}$	ne Ls, WV	26525
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications only one ca	ns that caus use on each	ed the death. line.	Do not ent	er the mode	e of dying	g, such as	cardiac (	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	2	Immediate Cause (Final disease or condition	a	acu	ten	uln	rong	tre	16	dei	na			4 days
	/Medical Examiner		resulting in death)		Due to (or a	s a consequer	nce of):	111	-0-		14	ease			marine
	Zxammer	-	Sequentially list conditions,	b	Due to (or a	as a consequer	T J	art.	RIC	1 0	110	ase		- 3	years
77.	end end I-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< −			v			200					
ć		Exa	that initiated events resulting in death) Last	c	Due to (or a	s a consequer	nce of):								
8760,	ate be ex hysicien the burie	dical		d											
9	ing ph	Med	IF FEMALE:	1											
Box	The law requires that the death certific ite has been signed by the ettending p age 2 should be deteched for use es	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1	Live birth	ne of pregnancy 2  Fetal de	ath 3	Ectopic pre					2	23d. Date of delive	ery Day Year
	the e	ysici	1 Yes 2 No 9 Unknown		I⊟Pregnant 9□Unknown	at time of deat	h 5[	Other (spe	ecify)						
P.0	thet ti ed by detec	F	Part II. Other significant condi	tions contribu	iting to death	but not resultir	ng in the u	nderlying ca	ause giye	en in Part I		23e. Did t	obacco u	se contribute to t	the cause of death?
ds,	ulres sign Id be	d b	dementia,	herre	thung	aid.	L4 06	rter	rse	en		10	Yes 2	No 3□Pro	babły 4 □Unknown
O	w requ	ete	Dialetos	Pra 1	00 01	_	1					24a. Was	an	24b. Were auto	opsy findings available
Re	The tay sete has page 2	E O	(CCC0 V-0   EZ)	191								autor perfo	rmed?	death?	ompletion of cause of 2□ No
ital		0	25. Was case referred to medic	al						26. Place	of Death	Check only o	-	10,163	2010
<b>&gt;</b>	S S E	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospi	1 U Inpa		VOutpatier	nt 3□ DO	A Othe	or 4 In	ırsing Ho	me 5□Resi	dence 6	3 □Other (Speci	fy)
0	Ing After		27. Manner of Dath 1 BNatural 5 ☐ Pend		Ba. Date of In (Month, D	jury 28 Day Year)	Bb. Time o Injury		Bc. Injury Work			28d. Describe I	now injun	y occurred	
Sio	death death stor: /	Cat	3 ☐ Suicide 6 ☐ Coul		Diago of I	Bium. At home		M		Yes 2□		28f Location /	Stroot and	d Number or Pur	al Route Number,
Division of Vital Records,	ofter of Direct of In by	Certification;	4 Homicide deter	mined 28	building,	njury - At home etc. <i>(Specify)</i>	e, rarm, su	eet, factory	, опісе			City or To			ai noute rumber,
	To the Hospital or Attand within 24 hours effer death To the Funeral Director; completely filled in by the	Medical C		l Examiner:		of examination								and manner as s place, and due t	
	To the within 2 To the comple	Me	29b. Signature and title of certif			1/		29c.	License	number			29d. Date	e signed (Month,	Day, Year)
			Marga	OX.	a di	Kun	M	)	DZ	66	D		4	-9-20c	08
			30. Name and address of person	n who comple	ted cause of	death (Item 23	За) (Туре,	Print)	ali			1	1	Λ /	112:00
		1	margaret	2 xa	iserm	d 13	279 G	rawe	an	gen	vay	Oak	lew	us , M	d 41550
	Sta Registr		31. Date filed Month, Day, Yea	9 2008	32. Regis	strar's Signatur		nach s	7	V	/				
3.	negiati	MI	Wi 17	V 2000	Jan 1963	AND AND AND	100								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

attriew Sonioza		- For State  - Registrar	ate of Maryland /		tificate of		ivieritai n		eg. No.	200	8 1273
Physiciar Medical Examin	n/	Decedent's Name (First, Midd						2. Date of Dea	ath Day	Year	3. Time of Death
meulcai Examin		Matthew Fabric  4a. Facility Name (if not institution			4	b. City, Town, or L	ocation of Deat	April 4, 20	4c. Cour	nty of Death	
**		University Hospital				Baltimore C	Lty			timore	
Funeral Director		5. Social Security Number 217 37 4023	6. Sex 7. Age	e (In yrs. la	ast birthday)  17 Yrs.	If Under 1 Year  Months Days	If Under 24Hr Hours Min	_		Cou	nplace (State or Foreign intry) 1ada
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits
land f show	٥		e Georges	Laur	el						1 X Yes 2 No
the Maryland is or 28a-f show	Director	10e. Street and Number 9015 A N.Laure	1 Rd.			10f. Zip Code 20723			10g. Citizen of Canada	What Count	try?
death with the Maryland or items 23a or 28a-f sho	L	11. Marital Status	12. Was Decedent Armed Forces?	Everin U.	S. 13. Was	Decedent of Hispes, specify Cuban,	anic Origin? ( S Mexican, Puert	Specify Yes or N	o- 14. R	ace - Americ /hite, etc.	can Indian, Black,
			lattieu i	No		Yes 2 No			Speci	ify: HISP	ANIC
lours al	à B	15. Decedent's Education (Spe	, , , , ,		16a. Decedent	's Usual Occupationst of working life.	on (Give kind of	work done		f Business/In	
5-0036 led within 72 hours after death with the Maryland thygiene. other than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	_	UDENT			STUDE	NT	
		17. Father's Name (First, Middle	, Last)			i		ne (First, Middle,	Maiden Surna	ime)	
2121 Uld be fil Mental I marked	ալ	Daniel Somoza  19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	Erin Gi and Number or		mber, City or	Town, State,	Zip Code)
MD d 2 sho lth and n 27 is		Daniel Somoza	FATHER			A N.Laur					
		20a. Method of Disposition  1 Burial 2 X Crematio	n 3 Removal from Sta	. i .	Place of Disposi crematory or oth	tion (Name of cem er place)		Date	1	on - City or T	
Baltimore, permit. Pages I ar Department of He. Important: If ite		4 Donation 5 Other S		Ri		Park Cro	em. 04	/09/2008	River	dale,	Maryland 1 Home,LLC
Ba perm Depa Impo injur	ŀ	Jurus In	net			05 12th					
Physician /Medical	7	3a. Part I. Enter the disease, o failure. List only one cause	e on each line.				uch as cardiac	or respiratory a	rest, shock, o	heart	Approximate Interval Between Onset and
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inj			plications					Death
		Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C								
uted Id ansit	Exa	events resulting in death) Last	Due to (or as a conse	equence o	f):						
be exectician ar	dica	X UNPENDED	AMENDED 23a,	27,28	a-f per m	E <b>g</b> 878 5/1,	/08 amh				
876C tificate ng phys	M/Me	23b. Was decedent pregnant in t	23c. If yes, outcomes the 1 Live birth	ne of preg		al death 3	Ectopic pregr	nancy	23d. Dat Mont	te of delivery th D	, Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Physician/	past 12 months?  1 Yes 2 No 9 Ur	y Pregnant at	time of de	oth	ner (Specify)					
P.O. I	by Pr	Part II. Other significant condi	tions contributing to death	but not re	esulting in the u	nderlying cause gi	ven in Part I.			ontribute to t	the cause of death?
aw requires	eted							24a. Wa	san 2	4b. Were au	topsy findings available completion of cause of
Recol	Completed							per	opsy formed? 2 No	death?	
tal Rection: The certificate ector, page	Be C	25. Was case referred to medic examiner?					of Death (Chec		7_		
of Vi ing Physi After this uneral dir	의	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie  28a. Date of Inju (Month, Day, Y		ER/Outpatient 28b. Time of Ir		y at Work?	28d. Describe	Residence how injury oc	curred	
ion (tending eath.	톑		iding (Month, Day,Y 4/1/08		8:20p	1 T	es 2 X No	auto	was a pe	destria	n struck by an
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. After this certificate To the Funeral Director. After this certificate completely filled in by the funeral director, page	Certification:	3 Suicide 6 Cou	uld not be 28e. Place of In		ome, farm, stree	et, factory, office bu	uilding, etc.	28f. Location or Town,	(Street and Ni State) Layh	umber or Ru ill Rd.	Route Number, City & Ballows Way,
To the Hospital within 24 hours To the Funeral completely filler		29a. Certifier 1 Certifying F	Physician: To the best of m	y knowled	ge, death occur	red at the time, da	te and place, ar	Silver S nd due to the ca	use(s) and ma	nner as state	ed.
Fo the within To the Complete	Medical	one) 2 Medical Ex	aminer: On the basis of examiner stated.	mination a	ind/or investigat	ion, in my opinion,	death occurred	at the time, dat	e and place, a	ind due to the	e cause(s)
2	Σ	29b. Signature and title of certification	w, m			29c. License O.C.N			29d. Date April 5,		nth, Day, Year)
	-	30. Name and address of perso		`	n 23a)				1	_	
SC	ŀ	Ling Li, MD Assista	ant Medical Examine	r 111	Penn Stree	t, Baltimore, I	MD 21201				
Sta Registr		APR 1 4 21108	32. Registra	r's Signati	ure						

State of Maryland / Department of Health and Mental Hygiene State
RegisAMEND#2,3,4c,perMD,&10b,perFH,4/14/08 Gentificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:08\_AM\_\_\_M Date of Death
 Month 3-24-2008 **Physician** 2008 Richard Lee Schmelyun March Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Harford Dove House Westminister If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 9/28/1936 Baltimore, Director 212-34-9048 71 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Carroll 1 X Yes 2 No Director MD Harford Taneytown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 "natural", or items 23a Funeral 10 Hayride Lane USA Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify ģ 3 Widowed 4 Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene.

Item 27 is marked other than other traumatic event, the M 12 Private Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Schmelyun Katherine Schaefer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $10~{\tt Hayride}~{\tt Lane}$ Shirley Schmelyun/Wife Taneytown, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4XDonation 5 ☐ Other (Specify) Howard University 3/27/08 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, N.W., Washington, DC 20011 Approximate Interval Between Onset and Death 3a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or he in failure. List only one cause on each line. Immediate Cause (Final **Physician** aMetastatic adenocarcinoma months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760 Physician/Medical as 1 attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus Type 2 1. Yes 2 No 3 Probably 4 Unknown as been signal 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas certificate ha perform 1☐ Yes 2 XVC 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl one Other: ၀ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6️▼Other (Specify) hospice After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural Natural 5 Pending 1 Yes 2 No thours after death.

uneral Director: A
ely filled in by the fu death. 2 Accident investigation 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D17040 March 31, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard G. Lanham, M.D. 215 Washington Heights Medical Center, Registrar's Signature Westminster, MD 21157 31. Date filed (Month, Day, Year) State APR 03 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🔠 🗓 🖯 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** APRIL 11,2008 1:03P ERNESTEEN SELLERS TAYLOR /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CHARLES CO.NURSING & REHAB. LA PLATA CHARLES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M Director 83 426-40-5204 22,1924 MISS Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. Yes 2 No MD. CHARLES LA PLATA Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10200 LA PLATA ROAD 20646 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2 No δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CHARLES CO Elementary/Secondary (0-12) College (1-4or 5+) BD. OF EDUC. TEACHER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy Sellers MODIE CARPENTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA TAYLOR-DAUGHTER 500 WASHINGTON AVE. LA PLATA MD. 20646 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 4-15-08 WALDORF, MD. 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Examl Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f o. 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed' 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, P. Division of Vital within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

2. Registrar's Signature MICHAEL 31. Date filed (Month, Day, Year) APR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 5:44 P™ 06, 2008 APRIL NATALLE S. THATCHER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON BOONSBORO REEDERS MEMORIAL HOME If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F 85 MAY 5, 1922 WASHINGTON. 579**-**18-6536 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MARYLAND WASHINGTON BOONSBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 U.S.A. 141 SOUTH MAIN STREET Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: Specify. à WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REPRESENT. UTILITY COMPANY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILIA POORE CHRISTOS SPANDOU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36 DIANNE COURT, CHARLES TOWN, WV 25414 JOSEPH W. THATCHER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 2 

Cremation 3 □ Removal from State 1 Burlan 4/07/2008 4 □ □ onation 5 Other (Specify) STAUFFER CREMATORY FREDERICK, MARYLAND neral Servic Lizensee 22. Name and Address of Facility ture of F 7606 Old National Pike 21. Sign BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANTE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 NO Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ■ Natural Injury 5 Pending investigation after death. 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Di 7019 DP Ru 7, 200 8 mp

31. Date filed (Month, Day, Year)

Dr. Vansant Datta

32. Registrar's Signature

340 Mill Street,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Hagerstown, MD

(301) 739-7100

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 1:30 P Janet Caroline VanJeune <u>April</u> 4 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Homewood Retirement Center Williamsport If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 218-30-2979 08/18/1935 DC 72 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 28a-f show at 1 ☐ Yes 2 No must be notified Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US ò 21740 1035 Mt. Aetna Road items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 11 Marital Status 1 Never Married 2 Married White 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify þ 3 ☐ Widowed 4 ♣ Divorced ear or Dates: "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than State Government the Secretary and Mental Hygie Is marked other Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Bernedine DuBord Francis Pierre VanJeune ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1112 S. Pine Street, York, PA 17403 Kathleen M. Sears/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Smithsburg Crematory 04/05/2008 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause and each line. Do not enter the mode of wing, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) eur. Physician /Medical o (or as a consequence of): Examiner Sequentially list conditions, it any, leading to infinance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Vear Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? significant contributing to death but no resulting in the underlying cause , ven in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. Date signed (Month, Day, Year) 29c. License number 29b. Signatur

JH-5+2

DHMH 17 Rev 1/2001

State

30. Name and address o

completed cause of

NETTH

death (Item 23a) (Type, Prin

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: /

> 31. Date filed (Month, Day, Year) APK LO ZUU

> > **OCMF**

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifier

Ana Rubio MD.

32. Registrar's Signature 1000

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 12, 2008

State

Registrar

Division or Vital Records, P.O. Box 68760,

death with the Maryland

**Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funear Director: After this certificate has been signed by the attending physician and seley filled in by the funear director, page 2 should be detached for use as the burial-transit cate has been signed by page 2 should be detact within 24 hours a To the Funeral L

		performed?   1   Yes 2   No									
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Normalizing Home 5 ☐ Residence 6 ☐ Other (Specify)										
27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Example 1	nysician: To the best of my knowledge, death occurred at the time, date and pmlner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)									

29c. License number

D(8019

21740

29d. Date signed (Month, Day, Year) AREIL 13, 2008

- put mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

340 Mill Street Hagerstown, MD Vasant Datta

State Registrar

29b. Signature and title of certifier

Medical

			= State Registrar			Cei	tificat	e of L	Death		Re	g, No.		
			Decedent's Name (First, Middle, Last)							2. [	th 3. Time of Death			
	Physicia		VICTORIA MARIE WELLS								PR.13			6:30P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)					Town, or	Location of De	4c. Cou	unty of Death			
	_xamii	•	5410 HARVEST F	ISH PLAC	Έ		W	ALDO	RF			CH.	ARLES	
	Funeral Director		548-92-01/01	7. Age	(In yrs. last 58	birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 H Hours Mi	in. (	Date of Birth Month, Day, 0-16-	Υθατ) 1950	9. Births Cour ILL	place (State or Foreign http) INOIS
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
Z15-UUSO thio 72 hours after death with the Maryland	aryla sho	5		r rec	roo. Oxy, v		WALD	ODE						1 ☐ Yes 21 No
	Ne M	Director	MARYLAND CHAR						Oc Citizeo	of What Cou	ntn/?			
	th with t 23s or 2 ust be n	al Dir	10e. Street and Number 5410 HARVEST FI	SH PLACE	3			2060		U.S.A.				
	72 hours after death with the Marylan "naturel", or Itema 23e or 28e-f show idical Examiner must ke notilied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Ever in U.S. No		Was Dece If Yes, spe 1  Yes		ent of Hispanic Origin? (Specify Yes or No- fy Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE						
ָבְּ	2 ho	Completed	15. Decedent's Education 16a. Dece					al Occupa	ation during most of v	vorkina		16b. Kind	of Business/In	dustry
7	within 72 ene. than nai	ple	Elementary/Secondary (0-12) College (1-4or 5+)					ise retired	)	voiking		F.B.	I.	
7	er th	Son	12	SEC										
Ore, Mary	al Hy	Be (	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (Fir	1   Yes 2 No  10g. Citizen of What Country? U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE  16b. Kind of Business/Industry F.D.I. U.S.GOVT.  First, Middle, Maiden Surname)  BECHTEL  Route Number, City or Town, State, Zip Code) C. WALDORF, MD. 20603  18 20c. Location - City or Town, State -08 CHELTENHAM, MD.  SERVICE, P.A.  46 respiratory arrest, Approximate Interval Between Onset and Death						
	Mental Merked o	2	JOSEPH STONES	IFER										
	t and 2 shou Health and M tem 27 is mar other traumat		19a. Informant's Name/Relationship (Ty				-							
	and ealth n 27 ser tr		MICHAEL WELLS-S	POUSE					r FISH		- Contract of the last of the			
	0		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	20b. Place ceme				ө) М. 4-	Date 17-(				
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	MO04	79 (	/ R	AYMO	OND 1	ss of Facility FUNERA MD 2	L SI	ERVIC	Ε,Ρ.	Α.	
	70		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused	the death. (	Do not en	er the mo	de of dyin	g, such as card	liac or res	spiratory arr	est,		Interval Between
	Physician		Immediate Cause (Final									4	Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as	a consequen									
	Examiner													
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ice of):								
60,	certificate be executed ding physician and se as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):										
68760	ficate phys s the	/Medical		3,										
O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 fhonths? 1 □ Yes 2 (2No) 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3[	⊒Ectopic p ⊒ Other (s					230	I. Date of deliv Month	rery Day Year
o.	The law requires that the death tie fas seen signed by the atterbage 2 should be detached for u	ρ	Part in. Other significant conditions continuous to death but not resouring in the onderlying cause given in Fart i.									DAMES		
0	require been signal	etec								_	04. 146		N45 N45	
Il Records,		Completed								_	24a. Was a autops perform	sy prior to completion of cause of		
Viital	yaician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					0.1	26. Place of I	Death (C	heck only or	10)		
5	Phyai this c	ပို	TE FOS ZENO	Hospital: 1   Inpatie		VOutpatie	- 1		4   Nutsiii	-	-		Other (Spec.	ify)
Division of	ding h h. After funer	atlon;	27. Manner of Death  17 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	3b. Time o Injury	of 28c. Injury at 28d. D Work? M 1 \( \text{Yes} \) 2 \( \text{No} \)			Scribe h	ow injury o	ccurrea		
Divis	in Sign	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, st	street, factory, office 28f. Location (Street and Number or Rural Rou City or Town, State)					al Route Number,		
	To the Hospital within 24 hours a To the Funeral completely filled	edical C		rsician: To the best iner: On the basis o and manner st	f examination									
	To the Ho within 24 To the Fu completely	Me	29b. Signature and title of certifier				25	9c. Licens	e number		2	9d. Date s	signed (Month	, Day, Year)
	- > - 0		> K Man	<u> </u>			1	72	F35	)		411	4/0	<u></u>

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ( F M) 20646

32. Registrar's Signature

	1 - For State Regis	e strar		Sta	te of N	Marylan	id / Depa	artmer rtifica			and M	ental Hy	/gien Reg. N	-2.0	08	12740
Physician /Medica	Leor	ent's Name (	zak								1	2. Date of D Month March	D:	2008	Year	3. Time of Death  8:30 P
Examine	Subu	ırban 1	Hospit					Bet	hesda	Location o		O. Data of D		Mont	gome	
Funeral Director	215-4	Security Num  44-372  sidence of December 1	5	6. Sex 1⊠ M 2		Age (In yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D Apr. 1	ay, Yea	946	Count Russ	
vith the Maryland or 28a-f show	10a. State 10b. County 10c. City, Town or Local														16	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
ath with th	10e. Stree	et and Numb							895_				U.	S.A.		
n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show sedical Examiner must be notified at	3 □ W	al Status ever Married Vidowed 4	_	ied 1 [	s Decede ned Force ] Yes 21 es, Give ar or Date	No		Was Dece If Yes, sp€ 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	0-	14. Race Black Specify:	- America , White, a	etc.
ed within 72 hours after death with the Maryland ygiene.  ver than "natural" or Items 23a or 28a-f show it, the Medical Examiner must be notified at	Elemer	1. (Specify ntary/Second	only highes		lege (1-40	or 5+)		kind of we DO NOT u	ork done d ise retired,	ation <i>luring most</i> )	t of workir	ng		Kind of Bus		lustry
d be filed wantal Hygie ed other tice event, the	17. Fathe	r's Name ( <i>Fi</i>			5+		Journ	alis	t			(First, Middle	e, Maide	Magaz n Surname		
s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical	19a. Info		e/Relationsl	nip (Type. Pri	nt)					and Numbe	er or Rura		r  nber, City or Town, State, Zip Code)  n, MD 20895			
Pages 1 avent of Heanont: If Item int: If Item iny or other	20a. Meth	nod of Dispos	sition Cremation	3 □Remova	I from Sta	16	Place of Disponentery, cred	sition (Na matory or	me of other place	e)		ate	20c. l	ocation - C	City or To	•
permit. Pages Department of Important: If It any Injury or conce.	21. Sign	LUA	arals m	Licensee		1000	De	2. Name a anzan	nd Addres	s of Facility	erg 1	lemori Rocky	al C	hape1	s, I	nc.
Physician	Immediat disease d	ick, or heart f te Cause (Fir or condition	allure. List	complications only one caus	e on each	ı line.	h. Do not ent		de of dyin	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death  2 years
	resulting in death)  Due to (or as a consequence of):  C.  Due to (or as a consequence of):															
death certifi e attending d for use as	IF FEMAI 23b. Was in th 1 □ 9 □	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown									_			23d. Date Mon		ery Day Year
requires that the een signed by th rould be detache	Pait II. Ot	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to														
The la	24a. Was an autopsy prior to death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes									ior to cor	psy findings available npletion of cause of 2 \( \) No					
al d	25. Was case referred to medical examiner?  1										/)					
Atten r deat ector by the	2 A 3 S 4 D	1 X Natural 5									r or Rura	I Route Number,				
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		eck only 2	CertifyIn Medical	g Physician: Examiner: Or an	To the be the basis d manner	s of examina	owledge, deat ation and/or in	h occurred vestigatio	at the tim	ne, date an olnion, dea	d place, a	and due to the	e cause(	s) and man	ner as st	tated. the cause(s)
Somy Somy	29b. Sign	nature and tit	le of certifié		3	2			c. License	number 5///	3			ate signed		Day, Year)
State	Steve	en Mic	hae1	who complete Schwar	t2, 1	1	400 Co	nnect		Ave.	#60	6 Kens	ingt	on, N	4D 20	)895
Registra		AP	R 03	2008	A.		K A	and the								

DHMH 17 Rev 1/2001

50N

MALCIAR

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 3. Time of Death 9:30 a 2 Date of Death 1. Decedent's Name (First, Middle, Last) 09 2008 **()**/4nth **Physician** Richard R. Walker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt. Lake Park Garrett 110 A Street If Under 1 Year | If Under 24 Hrs 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1**√**2 M 2□ F 73 Director 299-30-6218 07/13/1934 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and bental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director MD Garrett Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 U.S.A. 110 A Street apt. 224 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married Married 2☐ No Maryland 21215-0036 þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister Christian Ministery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Stewart Walker Elizabeth Hi11 ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 A Street Apt.224, Mt. Lake Park, MD 21550 Marilyn E. Walker/wife saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04/11/2008 | Morgantown, WV Omega Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 1 Son 1 32 S. Second Street, Oakland, Md 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cause - each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence 11): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the s should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

this certificate has ral director, page 2 Be Certification: To funeral After within 24 hours after dea h To the Funeral Director , completely filled in by the f

or Attending Physician:

To the Hospital

performed? Yes 2 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .harles NORTH

308

State Registrar

31. Date filed (Month, Day, Year) APR

29b. Signature and title of certifier

32. Registrar's Signature

Sharonda West Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 6, 2008 1322 hrs Medical Examiner Sharonda West 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 8850 Hampton Park Boulevard North Capitol Heights If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Washington 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Country) DC Director 1969 20. Dec. 1 M 2 XF 38 577-02-0759 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No 28a-f shov Washington District of Columbia permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20032 4632 Livingston Road, SE #203 ā 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes Specify: Black 1 Yes 2 No specify: Divorced If Yes, Give Year 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Baltimore, MD 21215-0036 Carpenter 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Darlene West</u> Michael Brown

19a. Informant's Name/Relationship (Type, Print ) ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4632 Rd., SE #203 Washington DC 20032 <u> Darlene West - Mother</u> 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Other Specify enature of Funera M Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and ore. List only one cause on each line. Mixed Drug Intoxication (Phencyclidine, Cocaine, Dextromethorphan) /Madical Death a Complicated by Drowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - trat Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/22/08 amh X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown è Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate has ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA ER/Outpatient 3 Inpatient 2 After this 1 🗸 Yes ۵ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 X No Natural Fnd 4/6/08 Pending Fnd 1:15p []nk Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. in by 6 X Could not be 3 or Town, State) 8850 Hampton Park Blvd. Capitol Hgts. Mil Suicide determined (Specify) Bathtub (found) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 7, 2008 O.C.M.E. ame and address of person who completed cause of eath (Item 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. Registrar's Signature 31. Date filed (Month, Day Year) State Registra DOME

ORIGINAL

			1 - For State Registrar	State of Marylan	•	artment of F		Reg	ene	12743		
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	ZIMMERM	AN			2. Date of Death Month	Day Year ©원 그일			
	Examir Funeral	ier	4a. Facility Name (If not institution, give  Carroll Hospita  5. Social Security Number  6. Sec	7. Age (In yrs.			stminster If Under 24 Hrs. Hours Min.	8. Date of Birth	rear)   C	oll  thplace (State or Foreign ountry)		
	Director		213-60-8261  Usual Residence of Decedent  10a. State  10b. County	54	Yrs. y, Town or Lo			Oct. 16,	1953 Ma	10d. Inside City Limits		
	th the Mar or 28e-f sl e notified	Director	Maryland Carroll Taneytown  10e. Street and Number 10f. Zip Code						g. Citizen of What C	1 ☐ Yes 2 🔀 No ountry?		
036	d within 72 hours after death with the Maryland Jene. r than "neturel", or Items 23s or 28e-f show the Medical Exammer meat be notified at	by Funeral	4508 Teeter  11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	Rd.  12. Was Decedent Ever in U. Armed Forces?  1	nes? If Yes, specify Cuban, Mexican, Puerro Rican, etc.)  XC No  1 ☐ Yes 2XC No Specify:					U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White		
Maryland 21215-0036	d within 72 piene. r than "nei	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	dent's Usual Occup kind of work done DO NOT use retired disable	during most of world)	sing	16b. Kind of Business/Industry  never worked			
ryland ;	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, I	To Be C	17. Father's Name (First, Middle, Last)  David E. Zimmer  19a. Informant's Name/Relationship (Ts		10h Maili	og Address (Street	Dori	e (First, Middle, M.  S Bowers	aiden Sumame) City or Town, State,	Zin Code)		
	ss 1 an of Heal item 2 r other		Doris Zimmerman/ m  20a. Method of Disposition  1 (XSBurial 2   Cremation 3   F	other 20b. F	4508	Teeter I	Rd. Ta	neytown,				
Baltimore,	permit. Pages Department of I Important: If its any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Cha	22	metery  Name and Addre	ess of FacilityHar	tzler Fur	Liberty neral Home o, MD 2179	9		
	Pnysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. aARRHY	h. Do not ent	er the mode of dyir WITH	ng, such as cardiac	or respiratory arres $Lar{\mathcal{E}}$	st,	Approximate Interval Between Onset and Death MIDUTES		
8760,	Medical Examiner  whysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): SCLER uence of): C	otic ci	ANDIONA:	SCULAR	)13 <i>E</i> 45 <i>E</i>	YEARS YEARS		
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and happe 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy	у		23d. Date of de Month	alivery Day Year		
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	nderlying cause giv	ven in Part I.		Did tobacco use contribute to the cause of t					
al Reco		Completed		ed? prior to	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No							
Division of Vital Records,	ng Physici Iter this ce ineral direc	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	ner: 4 ☐ Nursing H	th (Check only one ome 5 - Resider 28d. Describe how	nce 6 □Other (Sp	ecify)		
Divis	- 3 - c	Certification:	3 Suicide 6 Could not be 4 Homicide determined									
	To the Hospitel of within 24 hours aft To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one)  2	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my c	opinion, death occu	rred at the time, da	use(s) and manner a te and place, and du d. Date signed (Mor	ie to the cause(s)		
	wii To		30. Name and address of person who co	in therein	, M 2	D	14317	25	4 - 9 -			
ľ	Sta	ate		8 2008 Registrat's Signa	0		DRIVE	TANETTO	im new	2.787		
	Regist	rar	MINT	A LOCAL DESCRIPTION	20 20	13						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 30, 2008 Year **Physician** 10:55 P.™ Zelda Zeldin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Casey House Rockville Montgomery if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2120 F New York 120-16-7492 79 4, 1928 Director Apr. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show ideal Examiner must be notified at Washington 1 XYes 2 No D.C. None Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2412 19th Street N.W. #38 20009 United States permit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23; any injury or other traumatic event, the Mcclical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify. þ If Yes, Give Year or Dates: 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) Investor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Schiff Samuel Soloff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adria Zeldin/Daughter 2405 Colston Drive, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Georgetown University Medical Center 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licens 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endocrine Cancer disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 🛛 No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending Injury 1X Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 after death To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar

Medical

Genevieve Wroblewski, M.D. 31. Date filed (Month, Day, Year) APR 0 3 2008

and title of certifier

29a. Certifier

29b. Signatur



0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rockville,MD 20850

| Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0064615

1355 Piccard Drive

29d. Date signed (Month, Day, Year)

April 1, 2008

ØH−7 State

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 400 W. 7th Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Al)Vi Physician 12:45PM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TENESIS ARKWOOD Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9-23-20 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F Months Days 213-10-6526 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at BALTIMORE 1 Yes 2 No MD Director 10e. Street and Number 10g. Citizen of What Country? 9 21234 8720 EMGE ST. USA or items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than HOME HOMEMAKER OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be UNKNOWN UNKNOWN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEPT. OF AGING BALTO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 Warrial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 4-15-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Falility 21. Signature of Funeral Service Licensee SKARDA F.H. 2829 HUDSON ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Universe or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 KjUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy page certificate 1□ Yes 2☑ No director 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 X Natural 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

A pri ( ) (), 29b. Signature, and title of certifier 29c. License number D53682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. 4202 Baltimore 21 31. Date filed (Month, Day, Year) APR 21 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11 of the 12 of Maryland Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Дaу **Physician** Adams Faith 6,2008 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 115to er 24 Hrs. Baltimore 4 Social Security Number 8. Date of Birth Month, Day, 9. Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-66-628 Usual Residence of Decedent 1□M 2**X**F Months Maryland Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Experience must be notified at 1 XYes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21 21 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced 40 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) stome 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be ပ 7541 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter) 21244 Johnson 115 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State nsdowne, 22. Name and Address of Facility
Joseph L. Russ
2222 W. North 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses me P.A. 1216 23a. Paft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedi\* Re Cause (Final disease or condition resulting in death)

a. Due to (or as consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Por Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) ned by the a P.0. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 10 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ № 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P nspaniemi 4/16/08 DO057465 25 Main Street, Suite 200, Reisterstown, MD 2113 ( 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) PakeMP N.S. Ray 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Decedent's Name (First, Middle, Last)
 Barbara Jean Adams 3. Time of Death 2. Date of Death Month Apr 10, 2008 Year 10:23 P<sub>M</sub> **Physician** /Medical 4c. County of Deeth
Montgomery 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Olney Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Dec 18, 1933 Birthplace (State or Foreign Country)
 DC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F 577.46.4420 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No **Fulton** MD Howard Director 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number ŏ 20759 U.S.A. 7051 Pindell School Road 238 Funerai death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itama 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 20 Married White 1☐Yes 2XNo Specify Specify altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 'natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Postal clerk Wis i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie 1ent: If Item 27 is marked other figury or other treumatic avent. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **Ruth Richards** Thomas E. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7051 Pindell School Road Fulton, MD 20759 William E. Adams, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Dispesition permit. Pages
Department of t
Importent: If Ite
any injury or of
once. 1 Burial 2 Cremation 3 Removal from State Apr 15, 2008 Baltimore, MD **Bayview Crematory** \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A. 71 Old Columbia Pix 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death BREAST Immediate Cause (Final disease or condition resulting in death) cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed! 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No or Attending Physicien: Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Yes ANO 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗍 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature 035635 11, 2008 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add OLNEY 1181 Prina DR 707664 KAPLAN 32. Agistrar's Signatule 31. Date filed (Month, Day, Year), APR 21 State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** APRIL 22121 M 121 Joseph Baranowski 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Mar 23, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 □ F 71 216-32-8929 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show must be notified at 1 Yes 2 □ No Director MD Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2095 Rockrose Avenue 21211 USA Funeral tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 0 Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical unk unk filed within 72 than Elementary/Secondary (0-12) College (1-4or 5+) the unk unk other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Memorial Hospital 201 E. University Pkwy Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Sovice Licensee

Ronald Sowade, Director 4□Donation 5\\Other(Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MĎ Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 days BRAIN INJURY disease or condition resulting in death) ANOXIC /Medical Due to (or as a consequence of): Examiner 2 days ASPIRATION TERMINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed j physician and as the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending plant of for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe this certificate 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA ٩ 2 ER/Outpatient funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending Division 1 Natural 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 12, 2008 AT2438946

Registrar

State

30. Name and ad-

31. Date filed

MEMORIAL

JON

HOSPITAL

person who completed cause of death (Item 23a) (Type, Print)

MD

MOFFATT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Sower 2008 1:10 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner enthorne Baltimore 8. Date of Birth (Month, Day, Year) UC + 9,1934 Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 Months 83 218-18-80 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Des 2 No Baltimore notifled Completed by Funeral Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö must be 5227 slenthorne 23a USA 2123 Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 14. Race 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 110 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 THO Specify. Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mD 21237 Balto 100 5227 Glenthorne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State letro Grenatory 4 -24-08 4 Donation 5 Dother (Specify) 21. Signature of Fundamental Project Licensee 22. Name end Address I Facility 1232 Midvalley Dr. Jessup, PA18+34 error 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each incomplete the mode of dying, such as cardiac or respiratory arrest, limmediate Cause (Final disease or condition resulting in death)

a. Die to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1∐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2 1 2008

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H			iene 🛭 🗍	8 12751		
	Dhuniai		1. Decedent's Name (First, Middle, La	st)			-	2. Date of Deat Month	th Day	3. Time of Death		
	Physici /Medio		MORRIS	BE12661	R			4	16 2	008 10:45P M		
	Examir	er	4a. Facility Name (If not institution, giv				Location of Death		4c. County			
			Glen Burnie Hea			Glen Bu		1 . 5	Balt	Sirthplace (State or Foreign		
	Funeral		5. Social Security Number 6. Sex 220-12-9792 7. Age (In yrs. last birthday) 81 Yrs.    Tunder 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   4-3-1927									
	Director		Usual Residence of Decedent	373	81			4-3-	1921	MD		
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Man 1-f sh	to	MD I	A/N	Baltimo	re				14 Yes 2 □ No		
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Examinat must be notified at	Director	10e. Street and Number			10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	1	0g. Citizen of W	hat Country?		
	th wit	alD	2728 Fisk Road	Ē		21225	5		US	A		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		a - American Indian, k, White, etc.		
9	or It		1 Never Married 2 Married	1 ☐ Yes 2 <b>X</b> I If Yes, Give	No I	1 □ Yes <b>X</b> □XNo	Specify:	,		Black		
8	ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:								
7	"nat	lete	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most of work	ing	16b. Kind of Bu	siness/Industry		
21215-0036	filed within Hygiene. thar than "	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4or 5	D+)				Lumbe	er Company		
5		a)	17. Father's Name (First, Middle, Last	)	war war	ehouse V	18. Mother's Name	e (First, Middle, I	Maiden Sumam	θ)		
Maryland	should be nd Mental markad c umatic ev	To B	Coleman Berger Mamie Thomas									
	and 2 sho ealth and n 27 is mu		Marlene Berg	<i>Турв, Print)</i> er-Daught	1	ng Address (Street a Fisk Ro		a <i>l Route Number</i> Lto, MD				
Baltimore,	T is to		20a. Method of Disposition 1 ☐ Burial 2   Cremation 3	Removal from State		osition (Name of matory or other place unt Cem	θ)	- 1	20c. Location - (	City or Town, State		
ij	- 분류를		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice			2. Name and Addres						
B	permi Depa Impo any is		Kynette	K. Ime		1101 E.	North A	Avenue	Balto,	MD 21202		
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each li	the death. Do not ent ne.	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Finał disease or condition resulting in death)	a. Due to (or as	PIRATOR	Y FA	1URG					
	Examiner			Live	ER MA	LIGNA	NC4					
	D ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	Due to (or as a consequence of):							
D.	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	406 1	15645	6				
8760,	cate be executed obysician and the burial-transit	sal E		AA	GNIA							
9	death certificate e attending phys d for use as the	ledical		0								
Box	death certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy				e of delivery		
	ne deat the att hed for	Physician/M	in the past 12 months?  1 Yes 2 No	4☐Pregnant at		Other (specify)	NA		Mon	nth Day Year		
P.0	that the de ed by the detached		9 ☐ Unknown  Part II. Other significant conditions of	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contri	ibute to the cause of death?		
Vital Records,	w requires that the been signed by th should be detache	ed by	ARTERIOC	CLERATIO	C HOA	RT DI	158156	= 1 TY	es 212/No	3 Probably 4 Unknown		
000	e law requir has been s je 2 shoutd	ompleted	LEFT NE	PHREC	TORY TO	PANSITI	ONAL	24a. Was a autops	n 24b. V	Vere autopsy findings available prior to completion of cause of		
Ä	Th ate pag	Com		MALIGI				perforr	ned 🏏 📗 d	leath?		
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	(8)			
of \	di S	P.	1 ☐ Yes 2 ☑ No		ent 2 ER/Outpatier		4 Mursing Ho	me 5 Reside				
ouc	ding h. After funel	ertification;	27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury	Work	vat ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurre	ed		
Division	or Attanding after death. Diractor: After in by the funer	ficat	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	ury - At home, farm, str					er or Rural Route Number,		
Ö	- 9	O	4 Homicide	building, et	c. (Specify)		,	City or Town	n, State)			
	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical								nner as stated. and due to the cause(s)		
<b>L</b>	To th withir To th comp	Me	29b. Signature and title of certifler	al It	arthe	29c. License	number	2	9d. Date signed	(Month, Day, Year)		
•			Exercis M. F.	4TALING	SHUG SR	no i	0-18426	1	PRIL 1	8,2000		
	1		30 Name and address of person who	completed cause of d	leath (Item 23a) (Type,	Print)	MARO.	Auto	7/4	8,2000		
	1		372/ F0760	2 S Panion	ar's Signature	016	MANCYC	TND	4122	5		
	Sta Registr		APR Z 1 200	8 Server	ar s signature	le						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death

 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician**  $a^{M}$ William 4 17 Byrd, Jr 2008 6:02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3507 Woodstock Avenue N/A Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Ce2 Hours 1**⊠**M 2□F 2-20-1946 212-46-4777 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 No "natural", or items 23a or 28a-f sh dical Examiner must be notified Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3507 Woodstock Avenue 21213 П SA death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) the G E D Machine Operator marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Byrd, Sr Bernice Toney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Woodstock Avenue Balto, MD 21213 Shirley Byrd- Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4-25-2008 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD 21. Signature of Funora Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) Box 68760, ng physician a pe Physician/Medical attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 es 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed' certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 ☐ Nursing Home \*\* Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of eath 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Attending F (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident i or Attend after death Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C completely filled 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, distrar's Signature Year) 2008

and address of person who completed cause of death (Item 23a) (Type, Print)

BAUNMONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1000 F1 2008 10:36 AM ar. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Milton Be Himore 1027 NIA Husnue if Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Month, Day, Year)

Jan. 33, 1937 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary land 1 M 2 ☐ F Months Hours 2/6-32-6162 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County eltimere 1 Xes 2 No Margland Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number North 2/205 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🐪 No Baltimore, Maryland 21215-0036 Specify Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Flanagan 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Mabel Jones Sam 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) North Strapper Sit Clinton Smith Balton MO 21205 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memi Park Kanda (stora) 4 □ Donation 5 □ Other (Specify) 27 Name and Address of Facility Lillands 276 Fredhilten Pas 21. Sign Vr of Funeral Service Licensee 1.10 alvin Dulto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: present death.

Just after death.

Just after this certific.

filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2√ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Medical Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITM#5, perFH (8/9, 5/2/08, W)
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** HERBERI BRAMMER 7:00A M DU 2008 /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Riderwood Assisted Living Silver Spring If Under 1 Year | If Under 24 Hrs. Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Hours Min 8 /19 /1923 1**№** M 2□ F 84 <del>426</del>-14-2406 Texas Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Silver Spring Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 3160 Gracefield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ş 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Commission Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Coorpender Herbert Leslie Brammer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19950 Turnberry Dr., Tarzana, CA 91356 James Brammer/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) Chesapeake Crematory 4/18/2008 Beltsville, MD 22. Name and Address of Facility Papp Funeral + Cremation Services 21. Signature of Funeral Service Licensee 101443 933 Gist Ave; Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner KINSONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the s 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by decubi 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 25 No page 2 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide pgl.Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Voor Month **Physician** 0325 A 04 -16 Ernest Frost Cavey 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Coastal Hospice at Luke Birthplace (State or Foreign
 Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan 3, 1917 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Months Days Hours 91 Mary land Director 213-05-2852 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show notified at 1 ☐ Yes 2 ☐ No MD Directo Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or a 15 Moonshell Drive 21811 ms 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 Widowed 4 Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) steel worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Frost Cavey India Coomes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Cavey/spouse 15 Moonshell Drive Berlin, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) onalure of Funery Price Licepses Ade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) KINSON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Nopatient ٩ 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28¢. Certification: Injury at Work? Natural 5 ☐ Pending investigation Injury Jopital o. 4 hours after de. Peral Director: And to by the fire 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar HOSPICZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARY

31. Date filed (Month, Day, Year) APR 2 1

COASTA

Registrar's Signature

00058410

8.0 Box 1733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 8:55 PM **Physician** 2008 Oger ari /Medical 4c. County of Death 4a. Facility Name-Af not institution, give 4b. City, Town, or Location of Death street and number) Examiner Citx Richie Baltimore Hospice Josha If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Months 1 M 2 ☐ F 88 Yrs Hardvuille VA 27-12-0264 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore 1 XYes 2 □ No ral", or items 23a or 28a-f st Examiner must be notifled Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 livet U. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 77 is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trivat Constrution 12 Yr 18. Mother's Name (First, Middle, Maiden, Surname) 17. Father's Name (First, Middle, Last) Be ဥ CLY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 N. Mt Olivet La Baltimore MD. 21229 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Annie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State injury or 4-28-2008 Garrison Forest Cemetery Dwing Mills 4 ☐ Donation 5 ☐ Other (Specify) 814 upshur St NW. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tri-State Funeral Services 'n Washington Dc. W Nachum 23a. P. rt1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final renal Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner II Diubeter Sequentially list conditions, r as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Dav Year in the past 12 months? 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ small cell metastuses 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No ASCUD 1∐ Yes Demention Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ZNYATICHT Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04.19.2008 2041476 MD

State

Registrar

RAMOND W. WILSON
31. Date filed (Month, Day, Year)

30. Name an laddles of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

6565 N CHAPLES ST, SHITE 416, BALTIMORE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04 **Physician** CRAIA Kathrun /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death Examiner Baltimore Bayview Medical Certer If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🂢 F 216-01-9160 92 Director 01-03-1916 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be a 6571 Saint Helena Avenue 21222 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Head Teller Union Trust Bank or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mark Galliard Eleanor Fiorenza ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. Marsha A. Craig (Daughter) 14305 Indian Head Highway Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 04-21-2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 000 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) Examiner = antes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 1 ☐ Yes 2 ER/Outpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred М 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 ho

To the Function

death v

3altimore, Maryland 21215-0036

Pages

attending physician for use as the buria after death filled in by the 24 hours a e Funeral I

Medical Certification: To

5 ☐ Pending investigation 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

808

21124

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOKNE HOAK

31. Date filed (Month, Day, Year)

APR 21

Registrar's Signature

State

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥎 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:10 AM Η. 2008 Mae 9 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINDI HOSPITAL OF BALTIMORE BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Months Days 1 □ M 2 X F 212-12-2467 May 22, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💢 No Bel Air Maryland | Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 555 S. Atwood Road, #424 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specity: Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Store 12 Produce LOgistics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Woodward В. Hazelip Sophie James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Summit Circle Lakeville, Pennsylvania 18438 James E. Cox, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp: 4-22-2008 4 ☐ Donation 5 ☐ Other (Specify) Timonium Maryland 21. Sig ala of Meral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Precemonia O days disease or condition resulting in death) Due to (or as a consequence of): Septic-Hypothermic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypercarbic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary decase. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed 26. Place of Death (Check only one) Other: 4 \( \triangle \text{ Nursing Home} \) 5 \( \triangle \text{ Residence} \) 6 \( \triangle \text{Other} \) (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examine Physician/Medical as attending for use as signed by the ar Be Completed by I s certificate has be irector, page 2 s funeral director, ို Medical Certification: within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show r 28a-f show notified at

ms 23a or a

r than "natural", or Items the Medical Examiner me

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine.

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.

**Physician** 

Examiner

The law requires that the death certificate be executed

or Attending Physiclan:

To the Hospital

Division or Vital Records, P.O. Box 68760,

/Medical

Baltimore, Maryland 21215-0036

Funeral Director

Completed by

Be

2

25. Was case referred to medical

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

4 Homicide

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Penant Rattern, MRBS

RES-000

April, 19,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS, SINAI HOSPITAL OF BALTIMORE. BHARAT RATTANI

Registrar

10

31. Date filed (Month, Day, Year)
APR 2 1 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Marylan	-	artment of rtificate of		nd M		giene Reg. No. 2	008	12759
	Physic	ion	Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
it .	/Medi		Fred W. Cason					Apri	1 11,	2008	7:50 A M
	Examii	ner	4a. Facility Name (If not institution, give street and number)  144 Konrad Morgan Way		4b. City, Town,  Lothi		f Death			unty of Death Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs.</i> 229−14−6821 1 M 2□ F 84	last birthday) Yrs.	If Under 1 Year Months Days	r If Under 2	Min.	8. Date of Birti (Month, Day Nov . 12	, Year) , 1923	9. Birth	place (State or Foreign ntry) Virginia
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl I-f sho fied at	ţō		thian							1 □ Yes 2 No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 144 Konrad Morgan Way	•	10f. Zip Code 20711		-		10g. Citizen USA	of What Cou	ntry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ↑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 □ No If Yes, Give \( \text{Y} \) Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 XX		in? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occu kind of work done DO NOT use retire Stocker	during most ed)	of workin	ng		of Business/In	ndustry
Maryland 2	d 2 should be filed within in and Mental Hygiene. 7 Is marked other than "retraumatic event, the Med	To Be Co	17. Father's Name ( <i>First, Middle, Last</i> )  Clyde Cason			18. Mother		(First, Middle, Virgin	Maiden Sur		
<b>Jan</b>	2 sho and h is ma	ľ	19a. Informant's Name/Relationship (Type. Print)		ng Address (Stree				-		*
	Health Health tem 27 I		Betty M Cason - Wife  20a. Method of Disposition 20b. F	Place of Dispo	Konrad sition (Name of	- 1		Loth:		ID 2071 on - City or To	
Ē	Pages nent of nt: If if		Masurial 2 Ucremation 3 Hemoval from State	-	natory or other pla 11 Cemet	_ ′ i	-15-	-08		and, M	,
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr		21. In natural of Ineral Service Manager	22	2. Name and Addr 33 Old A	ess of Facility	Lee	Funera	al Hom	e, Inc	i, MD 20735
	Dhysisian		23a. Part 1 Enter the disease, or complications that caused the death shock, or heart follure. List only one cause on each line.						rest,		Approximate Interval Between Onset and Death
)	Physician / /Medical		disease condition resulting in death a. The Transfer of the condition of t		CAI	LAM	2				6mos
	Examiner	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	UAW7 uence of):	ME	Lyne	om	A	-		20425
8760,0	icate be executed physician and the burial-transit	dical Examiner	cause bisease or injury that initiated events resulting in death) Last  C  Due to (or as a consequence of the consequenc	uence of):							
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	Ectopic pregnand Other (specify)	су			23d.	Date of deliv Month	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resu	ılting in the ur	nderlying cause gi	ven in Part I.		23e. Did to		contribute to t o 3 ☐ Prol	he cause of death?
Il Records,		Completed					_	24a. Was a autop perfor 1□ Yes	sy	4b. Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Ot	hor:		(Check only or			
o	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	, of foy	4 □ Nur		ne 5 Resid		Other (Special curred	fy)
Division	I or Attending Is after death. Director: After I in by the funer	Certification:	1 ☑ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 4 □ Homicide determined (Month, Day Year)  (Month, Day Year)  (Month, Day Year)  (28e. Place of injury - At he building, etc. (Specification)	Injury ome, farm, stro y)	M 1	]Yes 2□N		8f. Location (S City or Tow	treet and Nu n, State)	umber or Run	al Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical Ce	29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the t vestigation, in my	time, date and opinion, deatl	d place, a	and due to the dead at the time, d	cause(s) and date and pla	i manner as s ce, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licen	se number i	VI	2	29d. Date sig	gned (Month,	Day, Year)
		)%	ANSTE MD		0101	0580	20	,	4/1	4/20	08
	6		30. Name and address of person who completed cause of death (Item STEVEW K. SELCAS	MAD					1	/	1.000
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 1 2008  32. Figistrar's Signa	tury de	books						
			MI II II T TOOL TOOL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death MORTHRIL **Physician** Pro . 50,018 11:20AM Κ. Collins Regina /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 X F Feb 28, Director 219-20-7734 81 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Timonium Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 should be filed within 72 hours after death v nd Mental Hygiene. marked other than "natural", or items 23s 12310 Rosslare Ridge Road, #303 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify: Specify ģ 3 ☑ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles John Kutcher Elizabeth Knorr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 nt of Health a 3535 Tenley Place Owings, Maryland 20736 Stephen C. Collins Son or other 20b. Place of Disposition (Name of Duraney Variatey)
Duraney Variety
Memorial Gardens Pages 1 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 4-23-2008 Timonium Maryland 21. Simplifier of run al Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR THROMBOSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and physician and the burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ATRIAL FIBRILLATION certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 17 No 24a Was an autopsy performe /es 2 1∏ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ N 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 1 Devatural Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

State Registrar

31. Date filed (Month, Day, Year) 2008 **APR 21** 

29b. Signature and title of certifier

JOGINDER P.



m-ella

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D41410

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 9:10 p M 2008 Judith Dawn Dales /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🗷 F Days Director 66 July 27, 1941 Maryland 214-40-4366 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a, State 10b County ed other than "natural", or items 23a or 28a-f show event, the Medical Examination at the motified at 1 ☐Yes 2 No Director Halethorpe Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 822 Sulphur Spring Road 21227 United States Completed by Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ₩idowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Private Education 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be nd Mental | James W. Sennett ၉ injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Glynis Lisiewski / Daughter 3547 Old Trail Road Edgewater, MD 21037 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/2008 Meadowridge Mem. Pk. Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility
Hubbard Funeral Home, Inc.
1407 Willens Avenue Baltimore, MD 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Physician ancer cev /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thousanding Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X / nknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 2 5 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? ispital or Attending Phours after death.
Ineral Director: After the filled in by the funers 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
AVC-1 17 2008 and title of certifier 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) horles St TONSON MD 26204 W) 31. Date filed (Month, Day, Year) State APR 1 9 2008 Registrar

April

ふるけ

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Reg. No.	16.176
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ralph E. Edward S		2. Date of Death Month Day	3. Time of Death 3.40 Pm
200	Examin		4a. Facility Name (If not institution, give street and number)  8 8 20 Walther BW	4b. City, Town, or Lo Pow Lovi 1  nirthday) If Under 1 Year   If Under 24 Hrs.	le Baltin	hplace (State or Foreign
	Funeral Director		5. Social Security Number  13507718  6. Sex 10 M 2 F  7. Age (In yrs. last to the second seco	Months Days Hours Min.	(Month, Day, Year) Co	w York
	e Maryland Ba-f show tiffed at	ctor		wn or Location arkville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 21	rai Director	10e. Street and Number 8820 Walther Blvd #2402	10f. Zip Code 21234	10g. Citizen of What Co USA	
020	72 hours after death with the Maryland natural', or items 23a or 28a-f show deal Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 ☒ No Specify:</li> </ul>	ecify Yes or No- Rican, etc.)  14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0020	hin 72 hours s. an "natural', Madical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/	/Industry
ind 21	uld be filed within 72 hc fental Hygiene. ked other than "natur tic event, the Medical	Be	12 5+  17. Father's Name (First, Middle, Last)  Charles A. Edwards		insurance (First, Middle, Maiden Surname)  . Watson	ee
Maryland	should ind Mer imarke umatic	₽ L	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Run	ral Route Number, City or Town, State, 2	
Baltimore, N	is 1 and of Healt Item 2 other			of Disposition (Name of tery, crematory or other place)	Date 20c. Location - City or	
Baltin	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral S rvice Licensee Wade, Director	State and Address of Facility Board Baltimore, MD 2120		Street
-	Physician /Medical Examiner	er	Sa. Part1. Enter the disease of complications that caused the death. D shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Coset and Death
x 68760,	eath certificete be executed attending physician and for use as the burial-transit	/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):		
P.O. Bo	Physicien: The law requires thet the death or this certificete has been signed by the attend and director, page 2 should be detached for us	Physician	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. $A + b$	23b. Did tobacco uae contribute 1 ☐ Yes 2 ☐ No 3 ☐ P	to the cause of death?
of Vital Records,	e law requires has been sign ge 2 should be	Completed by			24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
ital Re	hysicien: The la nis certificete has il director, page 2	Be Com	25. Was case referred to medical examiner?	26. Place of Deal	1 ☐ Yes 2 No th (Check only one)	1 □ Yes 20 No
ion of V	Attending Physic or death. ector: After this ce by the funeral dire	2	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Other: 4 Nursing Ho  Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	ome 5 Residence 6 Other ( <i>Spe</i> 28d. Describe how injury occurred	ecify)
Division	To the Hospital or Attending Phywithin 24 hours etter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home building, etc. (Specify)  29a. Certifier  Certifying Phyalcian: To the best of my knowled		28f. Location (Street and Number or Ricity or Town, State)	
	To the Hospital or within 24 hours effe To the Funeral Dirticompletely filled in	Medical	29a. Certifier  (Check only one)  Certifying Phyalcian: To the best of my knowlec (Check only one)  Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	and/or investigation, in my opinion, death occur  29c. License number	rred at the time, date and place, and du  29d. Date signed (Mon	e to the cause(s)
			30. Name and address of person who completed cause of death (Item 23	a) (Type, Print)	April K	2007
	Sta		31. Date filed (Month, Day, Year)  32. Magistrar's Signature  APR 2. 1 2008	Jalth 514 +	W (4 16 11 11)	41234

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylan		artment tificate			and M		giene Reg. No.	008	12	763
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month April	ath L4, Day 20	ΛΩ <sup>Year</sup>		of Death AM M
	/Medic		John Wesley Foy  4a. Facility Name (If not institution, give	street and number)			4b. City.	Town, or	Location o		APITI .		unty of Death		741
	Exami	er	401 N. Union Ave						de Gr				rford		
	Funeral Director		5. Social Security Number 6. Social Security Number 215–16–0742	x 7. Ag XDM 2□ F	e (In yrs 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir Month, Da July 1	Υθαί) 1, 192	9. Birth	nplace (State intry) 1Sy1va	or Foreign nia
	D .		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	eation							10d. Inside	City Limits
	h the Maryland r 28a-f ehow	ō	MD Harford		100.01	Havre		race							es 2√∑No
	28a-	rect	10e. Street and Number			- Havie	10f. Zip					10g. Citizen	of What Cor	untry?	
	death with the Maryland ms 23a or 28a-f ehow fourther hetiling at	aiD	401 N. Union Av	enue #A				210	78			U	SA		
936	or ite	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 MYes 2 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Oric n, Mexican Specify:	gin? (Spe , Pu <i>e</i> rto I	ncify Yes or No Rican, etc.)		Race - Amer Black, White ecify: wh	etc.	
2-0	72 hours "natural",	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	ient's Usua	Occupa	ition	t of worki	na	16b. Kind o	of Business/I	ndustry	unk
21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	!	kind of wor DO NOT us			OI WOIKII	19				
2 2	filed v Hygie ther t	S	10 17. Father's Name (First, Middle, Last)	0		sa	lespe	rson		r's Name	(First, Middle	Maiden Sun	name)		
an	id be ked o ic eve	To Be	George Wesley Fo	У							Nancy				
Maryland	shou and M s mar		19a. Informant's Name/Relationship (7						nd Numbe	r or Rura	I Route Numb	er, City or To	wn, State, Z		
	and 2 ealth a n 27 I		George W. Foy/so	n					Avenu		Havre	de Gr	ace, l	MD 21	.078
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other traumatic event, the Mone.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 ☒ Donation 5 □ Other (Specify		20b. P	Place of Dispo emetery, cren	sition (Nam natory or ot	ne of ther place	9)	D	ate	20c. Location	on - City or 1	Town, State	
Balt			21. Signature of Funeral Service Licen	Wade, Dir	ector		Ate A				655 W.	Balti	more	Stree	
	Physician /Medical Examiner	4	23a. hart1. Enter the lisea e, or compose, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. A den Due to (or as	a consequ	relmon				ſ		rrest,		Approxim Interval E Onset an	d Death
8760,	be executed ician and burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  d.	a consequ										
89	certificate iding phys	Medi	IF FEMALE:								- 100-1-11-1				
P.O. Box 68	0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Feta	Ideath 3	Ectopic pre Other (spe					23d.	Date of deli Month	very Day	Year
	w requires that the de been signed by the s should be detached (	þ	Part II. Other significant conditions of	entributing to death b	ut not resi	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco use o	contribute to		
Division of Vital Records,	The faw r ete has be page 2 sh	Completed									24a. Was autoj perio	osy rmed2	4b. Were au prior to d death? 1 \( \sum \text{Yes}	topsy finding completion o	s available cause of
/ita	Physician: Th this certificete rei director, pag	Be	25. Was case referred to medical examiner?	Hassital.				1 04		of Death	Check only	one			
of	Phys rthis ret dia	5	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatien 28b. Time of			4 🗆 190		ne 5 Nesi 28d. Describe			eify)	
on	Attending r death. ector: After y the fune	tion	1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	Bc. Injury Work 1 □ \	:?`` /es 2 □ l		EUG. DOSCIIDO	now injury oc	carred		
Divisi	il or Atter efter dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Inj building, et	ury - At ho c. (Specif)	ome, farm, str	eet, factory	, office		2	28f. Location ( City or To	Street and Ni vn, State)	umber or Ru	ral Route N	umber,
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	vsician: To the best iner: On the basis o and manner st	f examina	wledge, death tion and/or inv	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause	e(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c	. License	number			29d. Date si			)
			hom				D	00	036	10		04/1	15/0	8	
			30. Name and address of person who	ompteted cause of d	leath (Item	23a) (Type,	Print)	D	-1-		10 3	1017	_		
	Sta	to	Howard Yang. M 31. Date filed (Month, Day, Year)	€. Registr	ar's Siona	ture #	Plem	1 13	مر حمد	40 1	- 2	-1017			
	Registr		APR 2 1 200	ompteted cause of d	, Jr	Spar	W.	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2008 12:47a 18 April CATHERINE FORNEY **EMMA** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HAVRE DE GRACE HARFORD CO CITIZENS CARE NURING HOME If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 1 □ M 2 1 F AUG. 2 1919 MARYLAND 220-09-3492 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No HAVRE DE GRACE MARYLAND HARFORD CO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 415 MARKET ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE 3€XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) POLY SEAL MACHINE OPERATOR/BEAUTICIAN 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EMMA DRUMMER WILLIAM DRUMMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Dyer Drive, Clifton Park, N.Y., 12065 Walter G. Forney/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MIDDLE RIVER, MARYLAND HOLLY HILLS MEMORIAL 04-21-08 21. Signature of Funeral Service User 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, copposition, or heart failure. List only one cause on each line. Chronic Obstructure immediate Cause (Final yrs ø disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□No 1 Tyes 1☐ Yes 2☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ 1 No 1 🔲 Inpatient 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No M 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760,公 the attending certificate Physician: this After t or Attending death. Hospital

To the h

physician and s the burial-tran as esn detached signed by page 2 director. funeral within 24 hours after death To the Funeral Director: filled in by To the Fune completely fi

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural".

marked other

the Medical

Director

Funeral

ģ

Completed

Be

2

Examiner

by Physician/Medical

Completed

Be

Certification: To

4 ☐ Homicide

(Check only

the Maryland

death with

filed within 72 hours after

permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hotel Important: If item 2.7 is marked any Injury or other 2.7.

**Physician** 

/Medical

Examiner

Maryland 21215-0036

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Iwhan ND

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D3 - 60

4/18708

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milham 1106 Revolution St Kannychy MD

Harre De Grave MD 21078

		Am	Plea end #5, perFH g 1- For State Registrar	ase Type or Pri 883, 9/3/08 State of M	i <b>nt in E</b> TT <b>1</b> arylan		delible Ink artment of I rtificate of			l Copies ental Hy	0 6	jible.	1076	
9	Physici /Medi		1. Decedent's Name (First, Midd		rano		rinicate or	Deall	,	2. Date of De Month	eath Day	2008	3. Time of Death	n M
	Examir		4a. Facility Name (If not institution Johns Hopkins (2) 5. Social Security Name (2)	on, give street and number 3ayvicw Mdi	al (ev	J	4b. City, Town, 6  Satin	nore	of Death	8. Date of Bi	irth	ty of Death	place (State or Fore	pian
al.	Funeral Director		214-80- <del>3890</del> Usual Residence of Decedent	1√2 M 2□F	36	Yrs.	Months Days		Min.	July 9	<sup>y, Y</sup> 9971		yland	ngii
	he Marylan 8a-f show otified at	ector		ltimore	10c. City	y, Town or Lo	dale						10d. Inside City Lim 1 ☐ Yes 2 ☐ I	
	death with the same same or a must be n	Funeral Director	1 Weyburn Cou	12. Was Deceder		.S. 13.	10f. Zip Code 212 Was Decedent of		rigin? (Spe	ecify Yes or N		ISA ace - Amer	Ican Indian,	
9000	ours after d ral", or iten Examiner	b	1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	] No		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No			Rican, etc.)		ack, White		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or	5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire Ventory	during mo ed)		ng	Groc		ndustry	
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	17. Father's Name (First, Middle George	os	1		1	ner's Name		e, Maiden Surn. Alat				
			19a. Informant's Name/Relation  Evangeline Frai  20a. Method of Disposition		20h E	1 We	yburn Ct psition (Name of		ltimo			'		
Baltimore,	nit. Pages artment of I ortant: If ite injury or o		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (  21. Signature of Funeral Service	Specify)	e St	<ul> <li>Deme</li> </ul>	matory or other pla		4/21	/08	Cub H	lill,		
Ba	permi Depa Impor any ir		· MM-	WIIIIa	iii u.	Dau	5305 Har	ford	Rd.,	Baltim	nore, ME	212	Approximate Interval Between	
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pulm Due to (or a Due to (or a d.	s a conse A A k Ja conseq	uence of):  OS( CSS) uence of):	oertens)i							
P.O. Box 6	at the death certificate be by the attending physici tached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 🗆 Feta	ıl déath 3 [	⊒Ectopicpregnand ]Other <i>(specify)</i> _	су			70	Date of deli	very Day Year	
	w requires that been signed b should be deta		Part II. Other significant condit	ions contributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part	t I.		tobacco use co		the cause of death?	
Vital Records,		Completed by							<del></del>		s an 24i epsy formed? 2 \square No	o. Were autoprior to death? 1 ☐ Yes	topsy findings availa ompletion of cause of 2 No	ble of
or Vit	ysiclan: nis certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 Unpa	tient 2 🗆	ER/Outpatier	nt 3 DOA Ot	her		n <i>(Check only</i> me 5□Res	one) sidence 6 □C	ther (Spec	eify)	
Division o	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 Suicide 6 Could	igation not be 28e. Place of it	ay Year)	28b. Time o Injury ome, farm, str	Wo	Yes 2	□No	28f. Location	how injury occ (Street and Nur own, State)		ral Route Number,	
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	(Check only 2) Medica	ing Physician: To the besi Examiner: On the basis and manner	of examina									
	To the within 2	M	29b. Signature and title of certific	Le un	$\mathcal{Q}$		D44	se number 841			April	7.0	2008	
	le		Marc Suss	who completed cause of MID, MID	death (Item	n 23a) (Type, 140 E	astin F	tveni	ne, E	Baltimon	n.mD.	212	24	
R	Sta Registi		31. Date filed (Month, Day, Year APR 2	1 2008 32. P	trar's Signa	sture	askin f							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1:05 Pm Ewen James Fraser April 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Year | If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Pay Year) 10-17-1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Days 86 213-16-0488 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 🗓 No Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 N. Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1≿|Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White Specify: 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Truck Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Elizabeth G. O'Donnell

22. Name and Address of Facility Ruck Towson Funeral Home, Inc.

04-23-2008 | Timonium, MD

Approximate Interval Between Onset and Death

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1050 York Rd., Towson, MD 21204

210 East Lexington Street, Balt, MD 21202 of Disposition (Name of Date 20c. Location - City or Town, State

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

Be

Ewen Joseph Fraser

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

disease or condition resulting in death)

19a. Informant's Name/Relationship (Type. Print)

Harold H. Burns, Jr./Attorney

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached \$ Completed cate has b certificate Be Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Acther (Specify) NOSPLE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

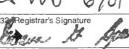
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 58303 29b. Signature

State Registrar

X

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 /Medical 4a. Facility Name (It not institution, give street and number) 4b. City Jown, or Location of Death Examiner 0/44519 CUC VUVSIU 104 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours M 2□F 552-26-3628 85 PA Director Dec 14, 1922 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 23a or 28a-f show at 1 ☐ Yes 2 No Examiner must be notified Columbia Howard Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6334 Cedar Lane 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S.

Armed Forces?

1 Nyes 2 No 194 2

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 72 hours after 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 9105 or Dates: Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Lewis Ford Maude unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 943 Oella Ave. Ellicott City, MD 21043 Kevin Ford 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD **Bayview Crematory** 22. Name and Address of Facility of Funeral Service Licensee Slack Funeral Home, P.A. 23a. Part1. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOC **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** OVOUQV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-tran and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No teen signed by the should be detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient ဥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After ! To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1. Natural 1 Tes 2 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifie 30. Name and address of p. r. n who completed cause of death (Item 23a) (Type, Print) 66 m 914

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mo.

# Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar				Certificate of	Death		g. No. 2	08	127				
an	Decedent's Nan	me (First, Middle, La	ast)				Date of Death     Month	Day	Year	3. Time of D				
al	D0104		rdner				3		80	11:05				
er	4a. Facility Name	(If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death		4c. County						
	Lorien	Taneyto			Taneyto	wn		CARR						
	5. Social Security		Sex 7. Ag 1 ☐ M 2 🛣 F	ge (In yrs. last bi	Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or intry)				
1	149-12-4	157		83	Yrs.		4 18	24	New	Jersey				
ł	Usual Residence of 10a. State	10b. County		10c. City, Tow	vn or Location				1	Od. Inside City				
5	mD.	Carro	11		tminster					1 Dixes 2				
Director			11	mes			Lac	0:::		NT.				
<u>-</u>	10e. Street and No				10f. Zip Code		10	g. Citizen of V	What Cour	ntry?				
ē	225	trock			2115			USA						
Funeral	11. Marital Status		12. Was Decedent Armed Forces?	?	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,					
by F		rried 2 Married	1 ☐ Yes 2 【 If Yes, Give	No	1 ☐ Yes 2 💢 No	Specify:		Specif	whi	te				
	3 Nidowed	4 Divorced	Year or Dates:											
Completed	(Spe	15. Decedent's E ecify only highest gr	Education rade completed)	16a 	a. Decedent's Usual Occu (Give kind of work done	during most of work	king	6b. Kind of Bu	usiness/In	dustry				
g.	Elementary/Sec	condary (0-12)	College (1-4or	5+)	`life. DO NOT use retire	/								
3	12		0		homekeep			own ho						
e n		e (First, Middle, Las					e (First, Middle, M		ne)					
0	James Sprunt Hall					Fleda M	arie Lle	wellyn						
	19a. Informant's N	Name/Relationship	(Type. Print)		b. Mailing Address (Stree			-						
	Bruce Ha	all/son		20	01 Stacy Lee	Drive We	stminste	r, MD 2	21157					
	20a. Method of Dis	•		- nomoto	of Disposition (Name of ery, crematory or other pla		Date 2	Oc. Location -	City or To	own, State				
		2 ☐ Cremation 3 [ 5 ☐ Other (Spec	Removal from State	Comete	, c.calory or other ple									
ŀ					22. Name and Addr	ess of Facility	1 (55 77	D - 1 - 1		7 <b></b>				
		Ronald S	Wade, Dir	ector				Baltim	ore :	Street				
-	222 Deat Fores		21. Signature of Funeral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201  23a. Pirtl. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
	23a. Parti. Enter	trie dise se, or cor			and and a standard of decidence	tana anata an an attan		-1		Ammunimate				
	mock, or ne	eart failure. List only	y one cause on each li	d the death. Do ine.	not enter the mode of dy	ing, such as cardiac	or respiratory arre	st,		Approximate Interval Between				
i	Immediate Cause disease or conditi	eart failure. List only e (Final ion	y one cause on each li	ine.		ing, such as cardiac	or respiratory arre	st,	٥	Approximate Interval Betwo Onset and De				
	Immediate Cause	eart failure. List only e (Final ion	y one cause on each li a. Due to (or as	ine.	of):				٥	Interval Between				
	Immediate Cause disease or conditi resulting in death)	eart failure. List only e (Final ion )	y one cause on each li a. Due to (or as	ine.	of):				un	Interval Between				
ner	Immediate Cause disease or conditi resulting in death)  Sequentially list of	eart failure. List only e (Final ion ) conditions, immediate	y one cause on each li  a. Due to (or as	ine.	nia				un	Interval Between				
aminer	Immediate Cause disease or conditi resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even	eart failure. List only (in a conditions, immediate letrlying or injury its	y one cause on each li  a. Due to (or as	ine.  sa consequence  Ch	nia				u	Interval Between				
	Immediate Cause disease or conditi resulting in death)  Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	eart failure. List only (in a conditions, immediate letrlying or injury its	a. Due to (or as	ine.  sa consequence  Ch	ma on: cetist				u	Interval Between				
g	Immediate Cause disease or conditi resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even	eart failure. List only (in a conditions, immediate letrlying or injury its	a. Due to (or as	s a consequence a consequence a consequence	ma on: cetist				u	Interval Between				
fedical Examiner	Immediate Cause disease or condition resulting in death;  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	eart failure. List only (in a conditions, immediate letrlying or injury its	a. Due to (or as	s a consequence a consequence a consequence	ma on: cetist				elen	Interval Between				
g	Immediate Cause disease or conditi resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even	eart failure. List only (inal ton) (in conditions, immediate derlying or injury ts	a. Due to (or as  b. Due to (or as  c. Due to (or as  d. 23c. If yes, outcome	ine.  a consequence a consequence a consequence a consequence	nin of):  mi Colist  of):  of):	nucline /		ryhOis	Little of delive	Interval Betwo				
2	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1:	eart failure. List only (in a list) only (in a list) on a list only (in a list) on a list only (in a list) on a list	a. Due to (or as  b. Due to (or as  c. Due to (or as  d. 23c. If yes, outcome	ine.  a consequence a consequence a consequence a consequence e pf pregnancy 2   Fetal deat	nin of):  mie Cetist of):	nucline /		ry iOss		Interval Betwo				
2	Immediate Cause disease or conditi resulting in death;  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede	ent failure. List only (inal ton)	a. Due to (or as  b. Due to (or as  c. Due to (or as  d	ine.  a consequence a consequence a consequence a consequence e pf pregnancy 2   Fetal deat	of):  of):  of):	nucline /		ry iOss	te of delive	Interval Betwo				
Filysician/Imedical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1.  1	ent failure. List only (in a list) only (in a list) on the conditions, immediate derlying or injury its (in a list) and the conditions (in a list) on the co	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):	ructure f	Pulmmu	ry Dis	te of delive	Interval Betwo				
by rilysicialitimedical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1.  1	ent failure. List only (in a list) only (in a list) on the conditions, immediate derlying or injury its (in a list) and the conditions of	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):  of):  of):  Other (specify)	ructure f	Pulmmu	23d. Da	te of delive	ery Day Ye				
by Physician/imedical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1.  1	ent failure. List only (in a list) only (in a list) on the conditions, immediate derlying or injury its (in a list) and the conditions of	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):  of):  of):  Other (specify)	ructure f	Pulmonu  23e. Did tob	23d. Da	te of delive	ery Day Ye				
by rilysicialitimedical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1.  1	ent failure. List only (in a list) only (in a list) on the conditions, immediate derlying or injury its (in a list) and the conditions of	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):  of):  of):  Other (specify)	ructure f	23e. Did tob 1 Tre 24a. Was ar autops'	23d. Da Mo	te of deliveranth	ery Day Ye				
by Physician/imedical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1.  1	ent failure. List only (in a list) only (in a list) on the conditions, immediate derlying or injury its (in a list) and the conditions of	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):  of):  of):  Other (specify)	ructure f	23e. Did tob 1 Pre 24a. Was ar autops; perform	23d. Da Mc acco use cont s 2 No	te of deliveranth	ery Day Ye				
completed by Litysician medical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to icause. Enter Und Cause (Disease othat initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final Ion) conditions, immediate derlying or injury its Last ent pregnant 2 months?	b. Due to (or as  d.  23c. If yes, outcome 1	ine.  a consequence a consequence a consequence a consequence pf pregnancy Consequence a time of death	of):  of):  of):  of):  of):  Other (specify)	ey	23e. Did tob 1 Pre 24a. Was ar autops; perform	23d. Da Mc acco use cont s 2 No 24b.	te of deliverenth	ery Day Ye posty findings ampletion of cause				
o be completed by Filysician/Medical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was deceded in the past 1: 1  Yes 2 9  Unknow  Part II. Other sign	ent failure. List only (Final Ion) conditions, immediate derlying or injury its Last ent pregnant 2 months?	a. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	ine.  a consequence a consequence a consequence a consequence b pf pregnancy 2 Fetal death at time of death but not resulting	of):  of):  of):  of):  h 3 Ectopic pregnant  5 Other (specify)  in the underlying cause gi	ey  ven in Part I.  26. Place of Deat	23e. Did tob 1 Tere 24a. Was ar autops: perform 1 Yes 2	23d. Da Mc acco use cont s 2 No 24b.	te of deliverenth	ery Day Ye Dably 4 Dur Dosy findings ampletion of cau				
to be completed by rangelorally medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was deceded in the past 1: 1 Yes 2 9 Unknow  Part II. Other sign	ent failure. List only (Final ton) conditions, immediate derlying or injury its 2 months? 2 months? 2 months? 2 months? 2 months?	b. Due to (or as  c. Due to (or as  d. Due to (or as  d. Due to (or as  d. Pregnant a goldnerm to death b  Hospital: 1   Inpatie	ine.  a consequence a consequence a a consequence a a consequence a consequence a consequence b a consequence a consequence a consequence b a consequenc	of):  ornic (2 list)  ornic (3 list)  ornic (4	ven in Part I.  26. Place of Deather: 4 Nursing Ho	23e. Did tob 1 Tre  24a. Was ar autops; perform 1 Yes 2	23d. Da Mc acco use cont s 2 No 24b.	te of deliveranth  stribute to ti  3 Prot  Were autor  prior to co death?  1 Yes	ery Day Ye Dably 4 Dur Dosy findings ampletion of cau				
to be completed by Filysician/Medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death.)  IF FEMALE: 23b. Was decede in the past 1. 1	ent failure. List only (Final ton) conditions, immediate gerlying or injury its Last ent pregnant 2 months? Conditions	y one cause on each li  a. Due to (or as  b. Due to (or as  c. Due to (or as  d. Due to (or as  d. Pregnant a 9 Unknown  contributing to death b	ine.  a consequence a consequence a a consequence a a consequence a consequence a consequence b a consequence a consequence a consequence b a consequenc	nof):  of):  of):  h 3 Ectopic pregnance 5 Other (specify) of the underlying cause given the underlyin	ven in Part I.  26. Place of Deather: 4 Nursing Ho	23e. Did tob  1 24a. Was ar autops: perform 1 Yes 2 th (Check only one	23d. Da Mc acco use cont s 2 No 24b.	te of deliveranth  stribute to ti  3 Prot  Were autor  prior to co death?  1 Yes	ery Day Ye Dably 4 Dur Dosy findings ampletion of cau				
to be completed by rangelorally medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final ton) conditions, immediate derlying or injury its Last ent pregnant 2 months? Information of the conditions erred to medical Info on the conditions  erred to medical Info on the condition of the co	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Hospital: 1 Inpatil (Month, Da Due to Inju (Month, Da Due to (or as	ine.  a consequence a consequence a consequence a consequence a consequence a consequence a pf pregnancy 2   Fetal deat at time of death but not resulting i	nof):  of):  of):  h 3 Ectopic pregnance 5 Other (specify) of the underlying cause given the underlyin	26. Place of Deather: 4 Nursing Horry at 17k?	23e. Did tob 1 Telescope 24a. Was are autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho	23d. Da Mo acco use cont s 2 No 24b. (ed? No viriginy occur	te of deliverenth teribute to the stribute to	ery Day Ye Dably 4 Ur opsy findings a mipletion of cau				
to be completed by rangelorally medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to icause. Enter Und Cause (Disease of that initiated even resulting in death.)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final ton) conditions, immediate derlying or injury its Last ent pregnant 2 months? Information of the conditions erred to medical Info on the conditions  erred to medical Info on the condition of the co	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Hospital: 1 Inpatil (Month, Da Due to Inju (Month, Da Due to (or as	ine.  a consequence a a consequence a a consequence a a consequence a a consequence b a consequence a consequence a consequence b a consequence b a consequence a consequence b a cons	of):  ornic (2 list)  of):  h 3   Ectopic pregnant 5   Other (specify)    in the underlying cause gi  utpatient 3   DOA   Ot  Time of   Z8c. Injury   M   1	26. Place of Deather: 4 Nursing Horry at 17k?	23e. Did tob  1 24a. Was ar autops: perform 1 Yes 2 th (Check only one ome 5 Reside 28d. Describe ho	23d. Da Mo acco use cont s 2 No 24b. (ed? No viriginy occur	te of deliverenth teribute to the stribute to	ery Day Ye Dably 4 Ur opsy findings a mipletion of cau				
commodule to be completed by thy stolar medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was deceded in the past 1. 1	ent failure. List only (Final Ion) conditions, immediate Jerlying or injury its Last ent pregnant 2 months? Information of the conditions erred to medical investigation of the condition of the	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence a a consequence a a consequence a a consequence a a consequence b pf pregnancy 2   Fetal deat at time of death but not resulting in cut	of):  of):  of):  h 3 Ectopic pregnand 5 Other (specify) _ in the underlying cause given the underlyin	ven in Part I.  26. Place of Deather: 4 Nursing Hork?    Yes 2   No	23e. Did tob  1 Te  24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town	23d. Da Mc acco use cont s 2 No 24b. Acco 24b. Acco 30 Octo	te of deliveranth  Tribute to ti	ery Day Ye Dably 4 Dropsy findings ampletion of cause of y)				
commodule to be completed by thy stolar medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to icause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final Ion) conditions. Immediate derlying or injury Is a conditions. Interpretation of the conditions of the condition of the condi	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence a a consequence b a consequence a consequence b a consequence a consequence b a consequence b a consequence b a consequence c a consequenc	of):  ornic (2 list)  of):  h 3   Ectopic pregnant 5   Other (specify)    in the underlying cause gi  utpatient 3   DOA   Ot  Time of   Z8c. Injury   M   1	ven in Part I.  26. Place of Deather: 4 Nursing Holling at 1016?  Yes 2 \( \text{No.} \)	23e. Did tob  1 Tre  24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town	23d. Da Mc acco use cont s 2 No 24b. (ed? No ) nce 6 Oth w injury occur eet and Numb State) use(s) and ma	te of deliverenth teribute to the stribute to	eny Day Ye Dably 4 Ur Dopsy findings a mipletion of cau				
commenced by mysician modern	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final Ion) conditions, immediate derlying or injury Iss (Section 1) Last ent pregnant 2 months? Ent of the medical investigation of the m	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence a a consequence b a consequence a consequence b a consequence a consequence b a consequence b a consequence b a consequence c a consequenc	of):  of):  h 3 Ectopic pregnance 5 Other (specify)  in the underlying cause given the underlying caus	26. Place of Deather: 4 Nursing Hours at 2 No	23e. Did tob  1 24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town , and due to the carred at the time, da	23d. Da Mc acco use cont s 2 No 24b. (ed? No 24b. winjury occur eet and Numb State) use(s) and matter and place,	te of deliverenth tribute to the stribute to t	ery Day Ye Dably 4 Ur Dopsy findings a mipletion of cause of the cause				
o be completed by Finysician/Medical	Immediate Cause disease or condition resulting in death.  Sequentially list of any, leading to icause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final Ion) conditions, immediate derlying or injury Iss (Section 1) Last ent pregnant 2 months? Ent of the medical investigation of the m	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence a a consequence b a consequence a consequence b a consequence a consequence b a consequence b a consequence b a consequence c a consequenc	of):  of):  h 3 Ectopic pregnance 5 Other (specify)  in the underlying cause given the underlying caus	ven in Part I.  26. Place of Deather: 4 Nursing Holling at 1016?  Yes 2 \( \text{No.} \)	23e. Did tob  1 24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town , and due to the carred at the time, da	23d. Da Mc acco use cont s 2 No 24b. (ed? No ) nce 6 Oth w injury occur eet and Numb State) use(s) and ma	te of deliverenth tribute to the stribute to t	ery Day Ye Dably 4 Ur Dopsy findings a mipletion of cause of the cause				
cermicanon. To be completed by Filysicialifiredical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	ent failure. List only (Final Ion) conditions, immediate derlying or injury Iss (Section 1) Last ent pregnant 2 months? Ent of the medical investigation of the m	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence a a consequence b a consequence a consequence b a consequence a consequence b a consequence b a consequence b a consequence c a consequenc	of):  of):  h 3 Ectopic pregnant 5 Other (specify) _  in the underlying cause given the underlying cau	ven in Part I.  26. Place of Deather: 4 Nursing Holly at 1017?  Yes 2 No  time, date and place opinion, death occurse number	23e. Did tob  1 Tre  24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town  and due to the carred at the time, da  28	23d. Da Mc acco use cont s 2 No 24b. (ed? No 24b. vinjury occur eet and Numb State) use(s) and ma te and place, dd. Date signe	te of deliverenth tribute to the stribute to t	eny Day Ye Day Ye Day He cause of de Dably 4 Ur Dopy findings an impletion of cau 2 No  My)  Mal Route Numb Stated. On the cause(s)  Day, Year)				
cermicanon. To be completed by Filysicialifiredical	Immediate Cause disease or condition resulting in death;  Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was deceded in the past 1. 1	ent failure. List only (Final Ion) conditions, immediate Jerlying or injury its Last  ent pregnant 2 months? In Ion conditions ent pregnant 2 months? In Ion conditions  erred to medical investigation ath 5 Pending investigation 6 Could not be determined.  1 Certifying P 2 Medical Exaudititle of certifier	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ine.  a consequence b consequence a consequence a consequence b consequence b consequence a consequence b conseque	of):  of):  of):  h 3 Ectopic pregnand 5 Other (specify) _ in the underlying cause given the underlyin	ven in Part I.  26. Place of Deather: 4 Nursing Holly at 1017?  Yes 2 No  time, date and place opinion, death occurse number	23e. Did tob  1 Tre  24a. Was ar autops: perform 1 Yes 2 th (Check only one 28d. Describe ho  28f. Location (Str. City or Town  and due to the carred at the time, da  28	23d. Da Mc acco use cont s 2 No 24b. (ed? No 24b. vinjury occur eet and Numb State) use(s) and ma te and place, dd. Date signe	te of deliverenth tribute to the stribute to t	eny Day Ye Day Ye Day He cause of de Dably 4 Ur Dopy findings an impletion of cau 2 No  My)  Mal Route Numb Stated. On the cause(s)  Day, Year)				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of iv	iai yiailu / i		rtificate of l		ı Mentai my	Reg. N		9 1	27	69
		П	1. Decedent's Name (First, Midd	le, Last)					2. Date of De	eath			e of De	ath
	Physicia /Medic		James		Griff	in			April	18,2	2008 Yea	2:	5	$\mathbf{P}^{M}$
-	Examin		4a. Facility Name (If not institution	n, give street and number	)		4b. City, Town, or	Location of Dea	ath	4	c. County of De	ath		
			Ivy Hall Nursin	g Home			Middle	River			Baltimo	re		
	Funeral		5. Social Security Number	6. Sex 7. A 1 □ XM 2 □ F	ge (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24 Hi		rth av. <i>Ye</i> a	r) 9. B	irthplace (St.	ate or F	oreign
	Director		212–18–4313	ILANVI ZLI F	85	Yrs.			June 1	1,1	922   Bal	timóre	lity,	,MD.
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Tow	n or Lo	cation					10d. Insid	e City I	Imits
	sho	ō											res 2](	
	he N	ect	Maryland Balti 10e. Street and Number	more	Dun	idal				10	Didi			
	a or	ā		, m., o			10f. Zip Code 2122	12	į	rog. (	Citizen of What ( USA	ouritry?		
	eath	era	1915 August Ave	12. Was Deceden	Ever in II S	12 \			/Specify Vos or N	2.	14. Race - An	orican India	2	
10	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atte event, it a Medical Eracinar must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar	Armed Forces	?		Was Decedent of H f Yes, specify Cuba		erto Rican, etc.)	J-	Black, Wh		1,	
21215-0036	al", o	by	3 ☐ Widowed 4 🛣 Divorced	If Vac Give			l∐Yes 2∭XNo	Specify:			Specify: W	nite		
Õ	2 hou	Completed	15. Deceder	nt's Education est grade completed)	16a	a. Deced	dent's Usual Occup	ation	<u> </u>	16b.	Kind of Busines	s/Industry		
21	hin 7 e. an "n Med	ed.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	kind of work done o OO NOT use retired	during most of w f)	rorking	f .				
21	d wil	S	12 years			Bre	adman			H	& S Bake	ery		
pu	al Hy l oth	Be (	17. Father's Name (First, Middle,						ame (First, Middle		en Surname)			
<u>la</u>	should b and Ment s marked umatic e	2	James R. Griffi	n				Anna Ba	umgardne	r				
Maryland	2 sho and i is ma rauma		19a. Informant's Name/Relations	ship (Type. Print)	198	b. Mailir	g Address (Street	and Number or	Rural Route Numb	oer, City	or Town, State	, Zip Code)		
	1 and 2 Health tem 27 i		Virginia Coyle	Friend			August Av	<u>·</u>	undalk,M	ary	land 2°	1222		
ore	of He		20a. Method of Disposition  ★□ Burial 2 □ Cremation	2 Demoved from Ctate	20b. Place o	of Dispo	sition (Name of natory or other plac	e) Apr	il <sup>Date</sup> 22,	20c.	Location - City of	r Town, Stat	Э	
<u><u>ĕ</u></u>	Pag ment ant: I ury o		4 □ Donation 5 □ Other (5		Gardens	of I	Taith Cemet	ery 20	800	Ros	sedale,	Maryla	ınd	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination in 11 and once.		21. Signature of Funeral Service	Licensee	00 -	22	Name and Address	uneral	Home Of	Dun	dalk,P.A	١.		
	= 4 O		Chichory	conne	lly	7	110 Solle	ers Poin	it Road,	Dun	dalk,MD.	2122		
			23a. art1. Enter the dise (se, o shock, or heart fallur	r complications that cause t only one cause on each	d the deam. Do ine.	not ent	er the mode of dyin	ng, such as cardi	iac or respiratory a	arrest,		Approx Interval Onset a	Betwee	en
	Physician		Immediate Cause (Final disease or condition	a			utia					1.7		T T
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	A COLUMN TO A COLU							,
		_	Sequentially list conditions.	b										
1/	sit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):								
V	and I-tran	хап	that initiated events resulting in death) Last	C. Due to for a	a consequence	of):								
60,	be e) ician burial	<u>e</u>	,	Due to (or as	a consequence	Oi).								
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical Examiner		d										
9 ×	ding page as	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy									
Вох	attendin for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death at time of death		Ectopic pregnancy	y		ľ	23d. Date of d Month	elivery Day	Ye a	ar
o.	at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of death	5 L	Other (specify) _							
σ.	that t		Part II. Other significant conditi	ons contributing to death	out not resulting i	n the ur	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause	of deat	th?
Records,	sign d be	d b	Paile	re +	+6 0°	00	, , ,		1 🗆	Yes	2 □ No 3 □	Probably 4	( Unk	nown
Ö	w requir	etec		40	1400				-					
3ec	: The law cate has   page 2 s	Completed	-						24a. Was	psv	prior to	autopsy findi completion	ngs ava of caus	illable se of
a F	lan; The rtificate tor, pag	ខ							1 □Yes	ormed?	death′ 1 ☐ Ye	s 2 No		
Vital	sician; certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			Oth		eath (Check only					
of	Phys	P	1 Yes 2 No	1 ☐ Inpat	ent 2 ER/O			4 🛮 Nursing	Home 5 ☐ Res			ecify)		
	ffe ffe	ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Inj (Month, D	ay, Year) 28b.	Time of Injury	28c. Injury Work	(?	28d. Describe	how inj	ury occurred			
Sic	Attending r death. ector: After by the funer	cat	2 Accident investi 3 Suicide 6 Could	not be	Add			Yes 2□No	001.1					
Division	or A	Certification:	4 ☐ Homicide determ	nined 28e. Place of in building, e	tc. (Specify)	arm, stre	eet, factory, office		City or To	Street wn, Sta	and Number or i ite)	Rural Route	Vumbei	5
_	pital ours a eral I filled		29a, Certifier 1 Certifying	ng Physician: To the bes	of my knowledg	o dooth	and urrad at the time	mo data and nia	and due to the		(a) and man-		-	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination ar	nd/or in	vestigation, in my o	pinion, death oc	curred at the time	, date a	nd place, and d	ue to the cau	se(s)	
	To th Within To th	Me	29b. Signature and title of certifie	·r	n Ar	0.5	29c. License	e number		29d. [	ate signed (Mo	oth, Day, Yea	r)	
			bone I Ohn	Loh	APV "	12	H	3550	3	4	4/211	08		
	6	ŀ	30. Name and address of person	who completed cause of	death (Item 23a)	(Type, I	Print)							
	り	_	De John L	-oh 112	4 Ms.	C = A	Aurei.	Ba	Hymo	4	MP	2/2.	2/	
	Sta		31. Date filed (Month, Day, Year)	2008 Regist	rar's Sign tare	Goo	de la		7					
	Registra	ar	Ut IV M T											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / [  1 - State Registrar	Department of F Certificate of			ene g. No. 2008	3 12770			
	Physicia		1. Decedent's Name (First, Middle, Last) Sharon Yvette Gray			2. Date of Death April 1		3. Time of Death 9:00 P M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 5617 Whitby Road		or Location of Death	1	4c. County of Dea	th			
	Funeral Director		5. Social Security Number 2 1 2 - 8 4 - 3 8 3 2	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir (Co. 1961 Ma	thplace (State or Foreign ountry) aryland			
	70	tor	Usual Residence of Decedent  10a. State	n or Location Baltin	more	Dair. 7,	1501	10d. Inside City Limits  MXYes 2 □ No			
	with the 3a or 28a t be noti	I Direc	10e. Street and Number S617 Whitby Road	10f. Zip Code	21206	10	g. Citizen of What Co				
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whi Specify:				
0-61717	I within 72 ho jene. r <b>than "natui</b> t <b>he Medical</b>	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 1 yr.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Case Mi	during most of work d)	king 1	6b. Kind of Business	/Industry Services			
מוומ	ild be filed lental Hyg ked other ic event, i	To Be C	17. Father's Name (First, Middle, Last) Alphonso Anderson		18. Mother's Nam	e (First, Middle, M	aiden Surname)				
Maly	nd 2 shou alth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type. Print) Kendall Gray/ Husband 56	Mailing Address (Street 517 Whitby	and Number or Ru Road Ba	ral Route Number, altimore	City or Town, State,	Zip Code) and 21206			
בי בו	Pages 1 a lent of Hes nt: If item ry or othe			f Disposition (Name of ry, crematory or other pla ern Cemete	ry 4/		Oc. Location - City or				
Dairillo	permit. Departm Importa any Inju		21. Signature of Funeral Service Ligensee	i				uneral Home e, MD21215			
į,	e Physician		25a Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	not enter the mode of dyin		or respiratory arre	st,	Approximate Interval Between Onset and Death			
ili sedi-	/Medical Examiner		Due to (or as a consequence			W C	Moon				
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):								
00/00	icate be executed physician and s the burial-transit	edical E	d								
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Vision   Yes 2 □ No	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	elivery Day Year			
ords, r.	ires that t signed by d be detac	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	ven in Part i.			o the cause of death?			
ו חפכסו	The law requate has been page 2 shoul	Completed				24a. Was an autopsy perform	prior to				
V 150	siclan; certific rector,	Be	25. Was case referred to medical examiner?  Hospital:	Ott	ner.	th (Check only one					
5	g Physier this teral di	n: To	27. Manner of Death 28a. Date of Injury 28b.	itpatient 3 DOA Cit	4 LI Nursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Spe w injury occurred	ecify)			
2	death. ctor: Af	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 🗆	]Yes 2 □No	28f. Location (Str.	eet and Number or F	tural Route Number			
2	oftal or A urs after eral Dire		4 Homicide determined building, etc. (Specify)			City or Town,	State)	, , , , , , , , , , , , , , , , , , ,			
	he Hosp n 24 hou he Fune pletely f	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.								
	To the To the Confinence of th	N	29b. Signature and title of certifier	29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)			
ţ			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	100-	1	, MD 2	1250			
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	VAUL DE	SAU	Merit	100) 5	1606			
	Registr	_	APR 1 9 2008	Devel 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 40AM terbert 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimence Baltimore 8335 mondons weet Cont Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/07/1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ F ŃΥ 79 Director 132-20-5198 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ira Modeal Exandrer must be notified at 1 ☐ Yes 2 🕅 No Funeral Director BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 8335 MEADOWSWEET ROAD 12. Was Decedent Ever in U.S.
Armed Forces?

1 Mayes 2 □ No WWI.
If Yes, Give
Year or Dates: ARM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2□No WWII 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: þ ARMY 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL WRITING CORPORATE EXECUTIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GHITZIS ESTHER** GENTCH NATHAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra BALTIMORE, MD 21208 8335 MEADOWSWEET ROAD, ANITA GHITZIS / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition NY 1 Description 2 Cremation 3 X Removal from State 04/18/2008 PINELAWN-LONG ISLAND, BETH MOSES 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 1010019 Cance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician sthe burials Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe certificate ! 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04-17-08 00059189

10

State Registrar 31. Date filed (Month, Day, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Zoz w. youst Signature Baltonia up

21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02818 State of Maryland / Department of Health and Mental Hygiene Keith Hamilton Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) n Physician/ Month Day April 10, 2008 0633 hrs Keith Orlando Hamilton Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Hours Country) 213-62-1237 1-13-1955 MD Director 53 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 No 23a or 28a-f show notified at once. N/A Baltimore Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 21213 USA 1734 Harford Avenue 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 11. Marital Status or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces 1 Never Married 2 Yes Specify: Black No specify: If Yes, Give Year Yes Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner <u>Ş</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) within 72 Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. N/A unemployed 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Madden Be Joseph Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 31419 110 Quail Forest Ct Savannah, GA Dorothy Deckard -Mother 20c. Location - City or Town, State nt: If item 2 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4-15-08 Balto, MD Carmel Cem tant: Μt Donation 5 Other Specify: 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licensee Balto, MD 21202 1101 E. North Avenue lad ) ane Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Hemoptysis complicating hypertensive atheroscleroticated Cause (Final disease a. cardiovascular disease with complications Death /Medical Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit AMENDED 23a,27, perME, g882 8/29/08 TT Physician/Medical X UNPENDED physician the burial certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE FEMALE Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 The law requires that the death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ð Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other 4 Nursing Home 5 Residence 6 Other Hospital: 1 ✓ Inpatient 2 DOA ER/Outpatient 3 this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey, Yeer) 28b. Time of Injury 27. Manner of Death After Certification 1 X Natural Yes 2 No Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Suicide (Specify)

Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death. filled in by the f Funeral completely To the

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State Registra

Medical

one)

Homicide

29b. Signature and title of certifier

Assistant Medical Examiner 3. Registrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 11, 2008

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

2008

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Lucille Halley 7 Apri1 2008 4c. County of Death 4b. City, Town, or Location of Death ${ t Clinton}$ 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Physician /Medical **Examiner Funeral** Director

1 - State Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ral", or Items 23a or 28a-f sh Examiner must be notified "natural",

Director

this certificate has

Completed by Funeral 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21/21/No Specify: 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator 0 17. Father's Name (First, Middle, Last) Be Newton 19a. Informant's Name/Relationship (Type. Print) Stephanie Everett (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal deat
4 □ Pregnant at time of death 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 25. Was case referred to medical examiner? Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2□ No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours are control to the Funeral Director. Aft 1 TYes 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide hom Drive 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) UNE CENTER 115045166 State Registrar DHMH 17 Rev 1/2001

Rebecca 6:00 PM 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Prince George's 8. Date of Birth (Month, Day, Year) April 30, 1908 Virginia 5. Social Security Number Birthplace (State or Foreign \_Country) Min. 1 □ M 2 👿 F Months Days Hours 577 01 1367 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 🕺 No MD P.G. Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5022 Leland Drive 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹₹↑ If Yes, Give Ā↑ Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 16b. Kind of Business/Industry Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Timber Wood Court, Gambrills, MD 21054 20c. Location - City or Town, State Cemetery April 16, 2008 Suitland, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735' 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28d. Describe how injury occurred rope 28f. Location (Street and Number or Rural Route Number City or Town, State) OXON 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 **Physician** Anthony Patrick Hyman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6 love's If Under 1 Year If Under 24 Hrs. 8. Date of Birth \_(Month, Day, Social Security Number 6. Sex 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1₩ 2□F Months Days Hours Min. 1984 MAryland 24 Jan 8, 215 08 2151 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Directo MD Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7556 Abbington Drive 20745 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 SpecifAfrican American 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Student College traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Anthony Scott ပ Paula Hyman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Hyman (Mother) 7556 Abbington Drive, Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April 17,2008 4 Donation 5 Other (Specify) Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Si nature of Fun ral or ice Licensee m0025 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Closed **Physician** /Medical Due to (or as a consequence of): Examiner Motor Vehic Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Yea 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 → No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [ Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of Injury
(Month, Day Year)

28b. Time of Injury
Injury
M
12
28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28d. Describe how injury occurred 2557 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural can struck Tre 1 ☐ Yes 2 ☐ No 2. Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar tal Drove

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Dav Year Vincent Hagman April 17 2008 5:25 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York **Funeral** 1X M 2□ F Months Days Hours Min 078-09-8835 Director 87 May 11, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits event, the Mictigal Ever insermust be notified at Directo 1 ☐ Yes 2 Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road, Apt. K-407 Funeral 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Affiled Forces:

1 Myes 2 □ No
If Yes, Give 1942-1945
Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 ₽ 1 ☐Yes 21 No 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>Auditor</u> <u>Department Store</u> Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic မ Paul Hagman Odert Esther Wickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109327 Department of Health Important: If item 27 any injury or other to once. Jean Hagman Wife 2525 Pot Spring Road, Apt K-407 Timonium, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐Other (Specify) Hilltop Service Corp. 4-18-2008 Towson Maryland 22. Name and Address of Facility rtice Licensee Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a.y., cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed 1 ☐Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1∐Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) HOSPICE ð 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1X Natural 5 Pending investigation iours after death.

neral Director: A
filled in by the fu death 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E

completely filled i 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 21

5008

VINCENT HAGMAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 312 M **Physician** Albert Beverly Haines /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City Baltimore City** Union Memorial Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours Maine 79 Dec 2, 1928 004-24-4544 Director Usual Residence of Decedent 10d Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Columbia MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21045 9418 North Penfield Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1953.
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 Mamed 2 X No 1 ☐ Yes f Yes, Give Year or Dates: Specify. White Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineering **Physical Engineer** 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First, Middle, Last) Be Annie R. Corey Albert W. Haines ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9418 North Penfield Rd. Columbia, MD 21045 Health tem 27 i Theresa Haines 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If Its any injury or o Burial 2 Cremation 3 ☐ Removal from State Clarksville, Maryland Apr 14, 2008 Columbia Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas Immediate Cause (Final disease or condition resulting in death) **Physician** Schemic Card /Medical Due to (or as a consequence of): Examiner Coconery ourde Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): the attending physician Division or Vital Records, P.O. Box 68760, Physician/Medical the ! for use as IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9□Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform The 2 **J** 1 ☐ Yes 2 No 1∐ Yes certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

Hospital or Attending hours after death.

who. In 24 hours Se Funeral Dro. Seilled in by within 0 2

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete

North Colvert St. #500, BACTIMIRE, MS 21218

3333

31. Date filed (Month, Day, Year)

29a. Certifier

APR 21 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOHN S. **JOHNSON** /Medical 4a. Facility Name, (If not institution, give street and number) or Location of Death 4c. County of Death Examiner TMOre N/A 8. Date of Birth (Month, Day, Year) 5. Social Segurity Number If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X1M 2□ F Yrs. Director 212-44-6824 61 MARYLAND MAR. 10 1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or iteme 200 control any Injury or other traumation. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 503 DOLPHIN ST. 21217 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1XXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUTCHER MEAT 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAURICE JOHNSON VERONICA LEE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Johnson/Mother 503 Dolphin St., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-19-08 BALTIMORE, MARYLAND 21. Sign tore of Funeral Service Lice Lee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Willana ( 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** astrointestinal Tract Bleeding if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Alcoholic Circhesis To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy þ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de ? þ 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မှ 1 npatient 2 ER/Outpatient 3 DOA 27. Mann of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: After

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 2



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ea

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5-25 pm JAMES YLVESTER APRIL 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PEHABILITATION EXTENDED CARE BARTIMONE Date of Birth (Month Day, Year) 47 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 217-50-2328 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 22 any injury or other trainment. 10c. City, Town or Location 10a, State 10b, County 10d. Inside City Limits N/A Baltimore MD 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21206 5426 Gardenwood Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: ty⊒Never Married 2☐ Married 1 ☐ Yes 2 🛱 No Specify. Specify: 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Exterminator 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie McClellam Archie James, Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Lochwood Balto, MD 21218 Martha Foster-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4-23-2008 Owing Mills, MD Garrison Forest 22. Name and Address of Facility 21. Signature of Fugeral Service Licensee March F/H East 1101 E. North Avenue Balto, MD 21202 tines 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TON GUE SQUAMOUS CELL CARCINOMY OF /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence off Examiner burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 🗔 🗐 0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ۴ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

> State Registrar

29b. Signature and title of certifier

3900 LOCH RAVEN BOULEVARD BACTIMUME MD 21218 THOMAS SMILLER 31. Date filed (Month, Day, Year) APR 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

030272

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	aryland			t Health and I of Death	•	giene : Reg. No.	_000	1270
	Sharalai		1. Decedent's Name (First, Middle, L	,					2. Date of De		Voor	3. Time of Death
e Ann	Physici /Medi		Margaret	Jane John	son				April	$15^{\text{bay}}$	$2008^{Year}$	8:54 A
	Examir		4a. Facility Name (If not institution, g			-		n, or Location of Death	1		ounty of Death	
913 913			Southern Mai				Clin				ince Ge	
	Funeral Director	0	578 54 2838	Sex 7. Ag	e (In yrs. las		If Under 1 Ye Months Da		8. Date of Bir Month, Da Feb 1	th 9, 194	9. Birthp	place (State or Foreig ntry) th Carolin
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Loca	tion					10d. Inside City Limit
	Maryl f sho led al	ō	Maryland Prince	George's		Suit	tland					1 □Yes 2□N
	the 28a-	Director	10e. Street and Number	000180 0		Dur	10f. Zip Coo	e		10g. Citize	en of What Cou	
	3a or		4813 Homer Av	re			207			Un:	ited Sta	ates
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	as Decedent	of Hispanic Origin? (S Cuban, Mexican, Puerl	pecify Yes or No		I. Race - Americ	can Indian,
9	after or ite	Fu	1 Never Married 2 Married	Armed Forces?  1  Yes 2  If Yes, Give X X Year or Dates:	No				o Hican, etc.)		Black, White,	
<u> </u>	ours iral",	d by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:			Yes 217	No Specify:		8	Specify: Blad	ck
2	72 h "natu dical	Completed	15. Decedent's (Specify only highest of	Education rade completed)	III.	16a. Decedei (Give kii	nt's Usual Oc nd of work do	cupation one during most of wor tired)	king	16b. Kind	of Business/In	dustry
2	vithin	m l	Elementary/Secondary (0-12)	College (1-4or 5	5+)		) NOT use re	tired)				
2	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, La.	st)		LPN		18. Mother's Nan	ne (First, Middle		alth	
ä	d be ental ced o	o Be	Martin Chamb						rice Rus		aa,	
$\mathbf{E}$	should and Men s marke umatic	ဍ	19a. Informant's Name/Relationship			19b. Mailing	Address (Str	eet and Number or Ru		-		 o Code}
Š	nd 2: alth al 27 Is r trau	'	Keith R. Johns	son (SON)				.E. Washin				, , , , , , , , , , , , , , , , , , , ,
ē,	of Hei	-	20a. Method of Disposition			e of Disposit netery, crema	and the same of th		Date ***		ation - City or Te	own, State
Ë	Pages nent of I ant: If its ary or o		1 🕅 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec					ional Ceme	terv	Suit	land. N	Maryland
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	gisee /		22.1	Vame and Ad	dress of Facility Le	e Funera	al Hon	ne Inc 6	633 "n1d
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each li	i the death. I ne.	Do not enter	exand: the mode of	ria Ferry	Road, CI or respiratory a	Lintor rrest,	, MD	Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequer	nce of):						
P	uted 1 nnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequer	nce of):						
o,	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequer	nce of):						
68/60,	ate be nysicia	edical		d								
_	ing ph	Med	IF FEMALE:									
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3□E	ctopic pregna Other <i>(specif</i> )			23	d. Date of delive Month	ery Day Year
	res that i igned by be detar		Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the unde	erlying cause	given in Part I.	23e. Did t	tobacco use	contribute to t	he cause of death?
ecords,	uires sign ld be	d by							1 🗆	Yes 2□	No 3 ☐ Prot	bably 4 Dunknow
Ö		ete							24a. Was	an	24h Mara puta	X
r	The la ate has page 2	Completed							auto		prior to co death? 1 \( \text{Yes}	opsy findings availabl impletion of cause of 2 No
VITal	stclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Dea				
0	Fi bi	2	1 Yes 2 No	1 ☐ Inpatie	<del></del>	Outpatient  Bb. Time of	3 DON		ome 5□ Resi			<i>fy)</i>
o	Ing Affer une	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, Da	y Year)	Injury	М	njury at Nork? I □ Yes 2 □ No	28d. Describe			
DIVISI	spital or Attend ours after death neral Director: A	Certifi	4 Homicide determine		ury - At home c. <i>(Specify)</i>	e, farm, stree	t, factory, offi	ce	28f. Location ( City or To		Number or Rura	al Route Number,
	e Hospital or A 24 hours after e Funeral Dire	dical	29a. Certifier (Check only one)  1XXCertifying F 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examinatior	edge, death on and/or inve	occurred at the stigation, in r	e time, date and place ny opinion, death occu	, and due to the irred at the time,	cause(s) a date and p	nd manner as s place, and due t	tated. o the cause(s)

To the Hospita within 24 hours To the Funeral completely filled

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801

Gargin Ave Sait 3-32 Silver Spring MD 20902

29c. License number

Du3 446

29d. Date signed (Month, Day, Year) 4.15.08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04 Month 19<sup>Day</sup> **Physician** 2008 Virginia Rosalind Maccubbin Jennings 7:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Care Center Towson Baltimore Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-6-1905 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕶 F 200-30-0490 Maryland **Director** Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Baltimore Funeral Director 1 ☐Yes 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Wedfeal Examiner must be none. 302 E. Joppa Road, #1302 21286 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 2 Specify: White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward Repp Grace Myrtle Kirby ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Williams / Daughter P.O. Box 10, Glenville, NC 28736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 4-22-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd., Towson, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final alure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e6, lite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for early pure signed by the attending physician and defected by the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -cardiovasula 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 2 No 1 ☐ Yes ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural 2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

V18619

Hegistrar

. Towsautown

ath (Item, 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 9878 4-21-08 vt. State of Maryland Poepariment of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Vera Marie Jorgensen Apr 10, 2008 4:00 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Friends Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2XF Director 578.24.1311 97 Denmar Jun 9, 1910 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 10c. City, Town or Location 1 Yes 2 No Director MD Montgomery Sandy Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 17340 Quaker Lane U.S.A. 20860 Funeral 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give 14. Race - American Indian, items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 11. Marital Status n "natural", or item ledical Examiner ⊓ Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 □ XVidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Translator Governmet 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jens Neilson Alexandra Clausen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Henry A. Jorgensen - son 5001 Castle Moor Drive Columbia, MD 21044-1402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr 19, 2008 All County Cremation Services. Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOOC35 Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence o Examiner die Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-trar Due to (or as a consequence of Box 68760. attending physician Physician/Medical the as for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1☐ Yes 2☐No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the a 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2**X** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA မှ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records,

Registrar

Ramani B. Reddy Friends Nursing Home 31. Date filed (Month, Day, Year) Registrar's Signature State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

20060089

29d. Date signed (Month. Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 Joseph James Kelley Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lions Manor Nursing Center Cumber land Allegany 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 76 Sept 2, 1931 Delaware Director 171-26-4135 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2√ No Funeral Director Cumberland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21502 901 Seton Drive 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I ∏ Yes 2 ☑ No f Yes, Give <sup>™</sup> Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. seasonal worker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) Be Joseph James Kelley Mary Williams ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lions manor Nursing Center 901 Seton Drive Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Euneral Short d S, Vade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ruch Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Non-small Cell Metastatic Aug. 2005 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tr Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 № 24a. Was an te has t autopsy 1∐ Yes 2 No certifical 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death I Director: After t d in by the funera Certification: 5 Pending investigation Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a. Certifier

(Check only one)

amar

29b. Signature and title of dertifier

Date filed (Month, Day, Year)

APR 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Scton Drive, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08 **Physician** ropkowski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name of not institution, give street and numbe Examiner CITT HOSPITAI 13A110. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex. 1 1 M 2 ☐ F Country) **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and the first 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt; If he Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 ☐Yes ♥☐No MY PERRY HALI Director 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ZYes 2 ☐ I Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lly 17. Father's Name (First, Middle, Last) Be ルログ はひひらバエ ို Mp. 211-1911 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1, Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-15-08 mn 22. Name and Address of Facility 252 9 HUDSCA of Funeral Service Licensee Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IDN Cancel **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hortic 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to milical examiner? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide determined 4 Homicide 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUCANE HOMA . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 19:32 M 2008 pencer /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Un K Examiner 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday If Under 1 Year **Funeral** Months Days Hours Min. 1**□**M 2□ F 62 June 1, 1945 Director Mississippl Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10a. State 10b. County on Ky r 28a-f show notified at 1 Yes 2 No **Funeral Director** DE Neway 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 40 East Main 19711 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Arm Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Compi 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)いっく Be Rever ပ Kathryn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Knight 40 Newark, Doan WIFE East Main St 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 13a HO1MP Metro Cremator 14-24-08 4 □ Donation 5 □ Other (Specify) 21. Signature of Ferenal Pervice Licensee 22. Name and Address of Facility I.AM 1232 Midvaller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C a se (Final disease or c a dition resulting in death) Physician Aure myocordial /Medical Due to (or as a consequence of): Examiner COIDARN Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) P.O. Box 68760, attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy certificate 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Medical ( 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kelllyno. DO062547 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLEUER UNION HOSP, 201 106 Bow Sneet, 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2

1

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** М Kalthof Frederick P. Sr. April 20 2008 23:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins - Bayview Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 216-20-7234 80 February 13,1928 | Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experience must be recified at 1 □Yes 2 TXNo Director Maryland Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9135 Cuchold Point Road 21219 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, Ith Maonce. Elementary/Secondary (0-12) College (1-4or 5+) B.G.E. 6 years Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Clifford Kalthof Sr. Josephine Rusnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Kalthof wife 9135 Cuchold Point Road, Sparrows Point, MD. 21219 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 24 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery Rosedale, Maryland 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. Approximate Interval Between Onset and Death Jentina lar Immediate Cause (Final Physician win5 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardwar Disacr b. Dik to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Examil burial-tran and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a P.O. 9 I Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 K No 1 ☐ Yes 2 ☐ Ño 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Xcertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature-eqd title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar

Dourt

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10101



D 39660

Rd. Bultimore, MD

April 21, 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	artment of Health and M	-	•						
	•	a POI	rtificate of Death		g. No.2 0 0 8	12787					
0		Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death					
Physici /Medio		Theodore Wilson Kizer, Sr.		April 18	2008 Year	5:20 P <sup>M</sup>					
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
	7	Riverview Care Center	Essex		Baltimore						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 \overline{\text{Sex}} \tag{71} Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 01/28/19	Year) 9. Birth Cou 13.7 Ponn	place (State or Foreign ntry) Sylvania					
Director		Usual Residence of Decedent		01/20/13	J/ Feins	syrvania					
yland how		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits					
e Mai	ctor	Maryland Baltimore Middle	River			1 ☐ Yes ¾☐xNo					
ith th	Director	10e. Street and Number	10f. Zip Code 21220		g. Citizen of What Cou	ntry?					
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  thy inter then "natural", or Items 23e or 28e-1 show ont, the Medical Exercit earmust be foothed at	rai	540 Carrollwood Road, Apt. A  11 Marital Status 12. Was Decedent Ever in U.S. 13.			U.S.A.	can Indian					
fler de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 11. Yes 2 ★ 12 ☐ Yes 2 ☐ Yes	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,						
O36 urs at at', or	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh:	ite					
5-0 72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business/Ir	ndustry					
21215-0036 d within 72 hours af giene. er then "natural", or	пр	Elementary/Secondary (0-12)   College (1-40r5+)		i							
filled v Hygie other t		6   Elect	rician	e (First, Middle, M	<u>Maintenance</u> Maiden Sumame)	9					
ed a la b	To Be	Wilson T. Kizer		E. Ensli							
shou and M mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rur			o Code) 21220					
and 2 alth a alth a 27 is er tre			Carrollwood Road,								
Ore of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date 2	Oc. Location - City or T	own, State					
Pages Pages ment of ent: If it		'4 □Donation 5 □ Other (Specify) Bayview			altimore, 1						
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny highry or other treumatic once.	-	21. Signature of Funeral Se Vice Licensee	2. Name and Address of Facility Bruzdzinsk	i Funera	l Home, P.	Α.					
20200	14	- Correction	1407 Old Eastern A	venue. E	ssex, Mary	land 21221 Approximate					
000000000000000000000000000000000000000		23a. Part . Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ther the mode of dying, such as cardiac	or respiratory arre	51,	Interval Between Onset and Death					
Pnysician /Medical		disease if condition resulting in death)  a. Dut if (or as a consequence of):	Center								
Examiner		A ca									
The same	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	jospenia.								
760, cape be executed residual and burial-transit		resulting in death) Last Due to (or as a consequence of):									
a % de	edical	d. Varhumiin									
Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph bage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	rery					
death death e atte	icia	in the past 12 months?  1 Ves 3 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year					
P.O.	hys	9 Unknown									
cords, P.O.  wrequires that the de been signed by the s should be detached	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pro						
Orc requi	eted										
Records, he law requires the has been signed age 2 should be contact.	Completed			24a. Was an autopsy perform	prior to co	opsy findings available empletion of cause of					
		25. Was case referred to medical		1□ Yes 2	No 1 □ Yes	2 No					
of Vital Physicien: Tribis certificat	o Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th <i>(Check</i> on <i>ly</i> one	nce 6 Other (Speci	ífv)					
Sion of Vita tending Physicien: leath. tor: After this certific the funeral director.	-	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe ho		9)					
VISION Attending r death. ector: After by the fune	atlo	2 Accident investigation	M 1 Yes 2 No								
	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui , State)	al Route Number,					
DIVI To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Ce	One Codifice ( Codificing Division To the Late of the Codification To the Codification	th parameter at the time of the and the	and due to the	woo(a) and	atatad					
To the Hospite within 24 hours To the Funerel completely filled	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal check only one)  2 Medicel Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	red at the time, da	use(s) and manner as a te and place, and due	to the cause(s)					
To the within 3	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month)	Dey, Year)					
r->r• 0		Mayel M.O	00055177		04/19/	08					
ĺ		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)								
		Sebastian John 3023 East	ern Arenne Bo	Home	Mo 21.	224					
Sta Regist		31. Date filed (Month, Day, Year)  APR 2 1 2008  APR 2 1 2008	1. 7								
negist	EII.	WILLY TOOM TOOME IN Tales									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MORIL HARTLEY KERSHNER 2008 OLIVER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 103 BATTMORE CLY BATIMORE UNIVERSITY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, 1 □M 2□ F 12/02/2007 220-79-9166 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No MD Baltimore City 10g. Citizen of What Country? 10e. Street and Number 703 W. University Pkwy. 21210 U.S.A. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Kershner Dawn Warner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Kershner / Mother 703 W. University Pkwy., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/22/2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatura f Funeral Service Lice 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SPINAL MUSCULAR resulting in death) Due to (or as a consequence of): Sequentially list conditions, fram, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year

Physician /Medical Examiner

Department of Important: If it any injury or o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

items 23a

ö

"natural",

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

must be

Examiner

other traumatic event, the Medical if Health and Mental Hygiene.

Completed by

Be

Examine burial-transi Completed by Physician/Medical the as attending | for use as ed by the a certificate has b Be 2 within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

this

Division or Vital Records, P.O. Box 68760,

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death

3 □Ectopic pregnancy 5 □ Other (specify) \_\_\_

Month

1 Yes 2 No 3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a Wasan

26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death

1 Matural

2 Accident

3 ☐ Suicide

4 Homicide

☐Yes 2☐No 9 ☐ Unknown

> 1 | Inpatient 28a. Date of Injury 5 ☐ Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other:

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6525 N. CHARLES ST SUITE 309

31. Date filed (Month, Day, Year) State Registrar

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 18, <u>Apri</u>l 2008 Maude E. Lamcke 8:10 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 719 Maiden Choice Lane HR535 Baltimore Catonsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Months 1 □ M 2 🔀 F 91 March 10,1917 Maryland 217-09-0869 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Maiden Choice Lane HR535 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Law 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Emerson Johnson Mary Etta Francis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Ruth Road; Arnold, MD 21012 James Johnson -Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cematory 4-21-2008 | Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 4 Donation 5 Dother (Specify) Metro Crematory 21. Sign Jur of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Varian ( ancel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2☐No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed 1☐ Yes 25. Was

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "y any injury or other traumatic event, the Medones.

the Me

**Physician** 

Examiner

**Funeral** 

Director

or 28a-f show notified at

o e

filed within 72 hours after death with an "natural", or Items 23a Medical Examiner must b

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division or Vital Records,

or Attending

Hospital within 24 hours a Director

Completed by Funeral

Be

/Medical

be executed ) physician and as the burial-trans as nding p esn after for u signed by the a ld be detached for been this certificate has

Examiner Physician/Medical ð Completed page 2 director, Be 2 After the funeral Certification: ours after death.

neral Director: A
filled in by the fu

31. Date filed (Month, Day, Year)

1□

case referred to medical		26. Place of Death (Check only one)						
niner? Yes 2010	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	e <del>5⊟ R</del> esidence 6 □Other				
ner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c.	Injury at Work?	d. Describe how injury occurred				

27. Man 1 ☐ Hatural 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ano

7008

(Specify)

Maiden 19 21.5

APR 21

32. Registrar's Signature

State Registrar

1 O

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 13:58 PM Jennis Magord April 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
der 1 Year I If Under 24 Hrs. Johns Hopkins Bayview medial center N/A 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 M 2 □ F Director 12-23-1952 Maryland 218-62-4858 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show 1 ☐ Yes 2 No must be notified Director Baltimore Baltimore Co. MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 2 Important: If Item 27 Is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n once. Funeral United States 517 South 45th Street 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Anchor Fence Co. 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be May E. Schock Henry C. McCord Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 517 South 45th Street Baltimore MD 21224 ( Mother ) May E. McCord 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-19-2008 Baltimore, Maryland 4□Donation 5束Other(Specify)Entombment Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk Maryland 21222 An1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** tai lure 8 hours Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 weeks Preumonio MRSA Sequentially list conditions, if any leading to initial discusse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examine 2 weeks al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Aureus Backremia Methicillin Vesistant Stophalococcus Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 1 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. Division or Vital Records, within 24 hours a

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) APR 2 1 2008 State Registrar

(Check only one)

Anjail

29b. Signature and title of certifier

Medical

am Sharrief . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

000

29d. Date signed (Month, Day, Year)

April 15, 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 22:38FM APRIL 2008 Ronald C. O'Connor 16. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Davs Hours 1 X M 2 □ F Aug 21, 1925 California 214-28-4777 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 'natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2√∑ No MD Baltimore Towson Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 615 Chestnut Avenue #1414 21204 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No 43-46 If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White **'**51-53 à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Cyril O'Connor Sr Helen Breitnieser 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn O'Connor/spouse 615 Chestnut AVenue #1414 Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Supplemental Supple Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE HEMORHAGIC CEREBROVASCULAR ACCIDENT HOURS /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-transi Due to (or as a consequence of): Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year for in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 ☐ Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 2 Be Certification: To

Box 68760. Division or Vital Records, P.O.

director, al or Attending F after death.

Director: A To the Hospital or within 24 hours af To the Funeral D

				24a. Was an autopsy performed? 1  Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
5. Was case referred to medical			26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/	/Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 ☐ Residence 6	☐Other (Specify)
7. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury '	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	e, farm, street, factory, off	fice	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,

29a. Certifier (Check only one)

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D39215

29b. Signature and title of certified

29c. License number 29d. Date signed (Month, Day, Year)

30. Name an, laddress of person who completed as se of death (Item 23a) (Type, Print)

7601 DRIVE TOWSON, MARYLAND CUNNINGHAM. OSLER GAIL

State Registrar APR 2 1 2008

December   Name (Frest, Michita, Last)   December   State of Death   December   Decemb	2702	2000 10	lental Hygiene Reg. No.		tment of H		of Maryla	State	ar	For State Registrar			
Security Name   Free of institutions, give a revert and number)   17   W. Cherry Street   Resing Sun   18   Sun	ime of Death	ay Year 3. Time o	2. Date of Death Month Day				рслет		s Name (First, Middle	1. Decedent's N	ian	Physici	3
Common   C	:38 P M	c. County of Death	4c.					, give street and no	ame (If not institution	4a. Facility Nam			
Total State   100. County   100. City rower stocklistics   101. Zip Code   110. Zip Code   1	_	9 Birthplace (State	8 Date of Birth	If Under 24 Hrs.	If Under 1 Year	- /		6. Sex	0-6932	5. Social Securi 215-40			
Physician Medical Examiner  Part I. The first he fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, improved the part fallure. List only one cause on each line.  Part II. Other significant conditions, in the past 12 months?  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant condi	side City Limits □Yes 2 🛛 No	1 □Yes	10g Citis						nd Cecil	10a. State  Marylan	ector	the Maryland 28a-f show notified at	10 mg/mm/mm/mm/mm/mm/mm/mm/mm/mm/mm/mm/mm/m
Physician Medical Examiner  Part I. The first he fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, improved the part fallure. List only one cause on each line.  Part II. Other significant conditions, in the past 12 months?  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant condi				L				reet			al Di	th with 23a or 1st be r	Alberta Ale
Physician //Medical Examiner  Part   Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, improved the part (a) provided the part	an,		Rican, etc.)	Specify:	□Yes 2⊠No	1	orces? 2[ <b>X</b> No ive	Armed F ed 1 ☐ Yes If Yes, G	er Married 2 Marrie	1 Never M	ρ	iours after dea ural", or items   Examiner mu	0000
Physician Medical Examiner  Part   Enter the fisease, or complications that caused the death. Do not earlier the mode of dying, such as cardiac or respiratory arrest, improved the part failure. List only one cause on each line.  Part   Due to (or as a consequence of):		·	ing	uring most of work	nd of work done d O NOT use retired)	(Give		t grade completed,	(Specify only highes		Complete	ed within 72 n giene. er than "natu , the Medical	-C1212
Physician //Medical Examiner  Part   Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, improved the part (a) provided the part			awley	Marion C		T			r Riedel	Walter	Be	nould be rie 1 Mental Hy na <b>rked oth</b> natic event	ylalıcı
Physician Medical Examiner  Physician Medical Examiner  23a. Part. Enter the 15ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final resulting in death) Last  25b. Place of Death (Page 1976)  25c. Was case referred to medical output page 100	21911	Maryland 219	ising Sun,	Street; R	Cherry S	17 W.	<b>W</b> 20b.	Daugh st- La	Prenderga of Disposition	Regina 1		es 1 and 2 sn of Health and litem 27 is m rother traum	Je, Mai
Physician / Medical Examiner  Physic	tzke	ridge, MD on Schwab Witz Inc.	2008 Elkr rling Ashto onsville, I	rk 4/21/	e Mem.Pa	adowrid	i State	pecify)	ation 5 Other (Sp	4□Donati		permit. Page Department of Important: If any injury or once.	
Due to (or as a consequence of):    Sequentially list conditions, arity, healing to hims date cause. Enter Underlying Cause Enter Underlying Cause Enter Underlying Cause (Bloaces or injury resulting in death) Last    Sequentially list conditions, arity, healing to hims date cause. Enter Underlying Cause (Bloaces or injury resulting in death) Last    Due to (or as a consequence of):		Approxima Interval Be		, such as cardiac o	the mode of dying	th. Do not ente	each line. SSPIN	only one cause on	or heart failure. List o Cause (Final condition	shock, or Immediate Cau disease or con-		hysician	P
Due to (or as a consequence of):    Comparison of the control of t	DA4S MOS	27		0	. /	S/S	C178.	b. A	list conditions	Sequentially lis	ner	Examiner	E
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Mos	13 M				U C, quence of):	(or as a conse	c. Due to	ase or injury events leath) Last	Cause (Disease that initiated ev resulting in dea	dical Exam	ate be execure thysician and the burial-trans	or ou,
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of perturbations of the cause of th	Year	,				al death 3	birth 2 Fet nant at time of	1 ☐Live 4 ☐ Preg	ast 12 months? s 2 X No	23b. Was dece in the pas 1 \(\sigma\) Yes	ysician/Me	the death certury y the attending packed for use as	the death cartific
24a. Was an autopsy finc prior to completion death?  25. Was case referred to medical examiner?  1		*		n in Part I.	erlying cause give	sulting in the un	leath but not re	ns contributing to c	significant condition	Part II. Other si	by P	equires unar	ruines that
26. Place of Death (Check only one)  27. Manner of Death   Natural   5   Pending investigation   28a. Date of Injury   28b. Time of	n of cause of		autopsy performed?									icate has be r, page 2 sh	The law r
28a. Date of Injury  Work?  1 Natural  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury  Work?  1 Yes 2 No  28b. Dime of Injury at Work?  28b. Dime of Injury at Work?  28c. Nijury at Work?  2b. Dime of Injury at Work?  1 Yes 2 No  28b. Dime of Injury at Work?  2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  1 Yes 2 No  2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  1 Yes 2 No  2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  1 Yes 2 No  2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  1 Yes 2b. Dime of Injury at Work?  2b. Dime of Injury at Work?  1 Yes 2b. Dime of Injury at Work?  1 Ye		6 □Other (Specify)				ER/Outpatient	Inpatient 2[	Hospital:	?	examiner?	0	is certif director	weigiar
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and fittle of certifier  29b. Signature and fittle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type Print)	e Number,	ury occurred and Number or Rural Route Num	28d. Describe how injury 28f. Location (Street and	at ? ′es 2 □ No	28c. Injury Work' M 1 ☐ Y	Injury ome, farm, stre	nth, Day Year)	ation (Mor	ral 5 ☐ Pending dent investiga ide 6 ☐ Could	1 X Natural 2 ☐ Accider 3 ☐ Suicide		affer death. I Director: Affer the	of or Attending Pt
29b. Signature and fittle of certifier  29c. License number  29d. Date signed (Month, Day, Ye  17 - ATPR - 2  30. Name and autress of person who completed cause of death (Item 23a) (Type Print)	` '	nd place, and due to the cause(	ed at the time, date and	inion, death occurr	stigation, in my op	ation and/or inv	pasis of examin nner stated.	Examiner: On the tand mar	only 2 Medical E	(Check only one)		n 24 hours he Funera pletely fille	A Hospits
30. Name and address of person who completed cause of death (Item 23a) (Type Print)	ear) 20 <i>6</i> 8	ate signed (Month, Day, Year) $7 - \mathcal{ATR} - Zo$	29d. Date	number 6 S' o 1	29c. License	vie n	· Au	P. M	re and little of certifier	29b. Signature	2	withi Com	Tot
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature	MD 2122	· Baltinen H	Squar Dr.	ranklin	9163 7	n 23a) (Type, F M 9 ature	se of death (Ite /////E Registrar's Sign	nho completed cau	d andress of person w	30. Name and a	4 9	) Sta	M

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 16, 2008 **Physician** 11:50 AM Doris C. Pluhar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson Baltimore Gilchrist Center 7. Age (In yrs. last birthday)
79 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min. Months 1 □ M 2 🛛 F Days Hours 1929 Maryland Director 213-26-6238 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f sho event, it e Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 19 Rolling Greens Court 21093 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Herbert Cypull Helen Klutch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trauonce. 19 Rolling Greens Court, Lutherville, MD. 21093 Lawrence Pluhar (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Garrison Forest Vet. Cem. 04/22/08 Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatur Funer Pervice Lice ee 1050 York Road, Towson, Maryland 21204 Approximate Interval Between Onset and Death ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** AMU OWNER years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of). Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕬 o 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 Do 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) Nasy LO Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 58303 APML 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in 6701 N. Charles ST Tow son un 21204 ANIN J. CHAMES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10:25 a<sup>M</sup> April 2008 JOHN HAROLD RHINES JR. 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death N/A BALTIMORE GILCHRIST FOR HOSPICE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F 64 FLORIDA 219-40-0595 DEC. 25 1943 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1XXXyes 2 □ No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2220 ERDMAND AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 ☐ Yes 2 X Xo

If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 XXIIo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7yrs LAWYER/ATTORNEY T.AW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GLADYS GRANT JOHN H RHINES SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Erdman Ave., Baltimore, Maryland 21213 Royreal Brown-Rhines/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-23-08 BALTIMORE, MARYLAND METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Dellera C Houn 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ceus Due to (or as a consequence of): unvy 11 Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Vear Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25 Was case referred to medical

Physician /Medical Examiner

attending p

signed by the a

page 2 s

To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral

2

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

show

Funeral

þ

Completed

Be

2

artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modical Examinar must but withfled at

1 and 2 should be fill Health and Mental H Mm 27 is marked oth

Pages 1

Maryland 21215-0036

Baltimore,

P.O. Box 68760, certificate be

Vital Records,

vision of

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

eveminar?		Zo. Place of Dea	till (Check brilly brie)		
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐ D	OCA Other: 4 Nursing H	lome 5 Residence	6 Other (Specify) WSPUL
Z LI Accident	igation	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide deterr		nome, farm, street, factor ify)	ry, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
On Cartifica Amazantes	ne Dhuaislan. To the heat of my les	auladaa daath aasuuna	d at the time. Jota and place		/=\ ===d

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatur and title of certifier Name and address of person who completed cause of death (Item 23a) (Type

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

APR 21

H

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Valarie Ray 9 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 226 N. Spring Ct Baltimore N/A Date of Birth (Month, Day, Year) 6-23-1953 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2/X 54 Director 216-62-5411 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 N. Spring Ct 21231 U Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □ Yes 2√√No Specify. Specify: à 3 Nidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other ti any injury or other traumatic event, the once. 10th grade Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Rivers Alice Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Acquanetta Johnson-Sister 7503 Digby Road Balto, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Parial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 4-16-2008 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East & lade W 1101 E. North Avenue Balto, MD ans 23a. Part1. Enter the diseasa or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Per pheraf Due to (or 's a consequence of Vascular DZ /Medical Examiner Britle Diabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Recurrent attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, percholesterolemia use as IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an ate has page 2 s autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death. I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

Year

6:00 pM

MD

1 X Yes 2 □ No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

Birthplace (State or Foreign Country)

Black

J

State Registrar

Orleans 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

B9110

2008

St

29c. License number

D0064142

		-	For State Registrar		State of Ma	aryland	-	partment of I e <i>rtificate of</i>			Mental Hy			5	
			Registrar     Decedent's Name	(First, Middle, La	st)			er timeate or	Dea		2. Date of De		Z U !	18	3. Time of Death
	Physicia /Medic		HARRY :	I. ROGERS	S, JR.						MATHR:		198, 21	21218	01:00AM
	Examin		4a. Facility Name (If	notinstitution, giv Joseph	e street and number) Medical	Cen	ter	4b. City, Town,	or Locati	ion of Deat	5 O TI	4	c. County of	Death Ellti	more
	Funeral Director		5. Social Security Nu 217-09-3		ex 7. Age	e (In yrs. la	st birthda Yrs.	y) If Under 1 Year Months Days	If Un Hou	irs Min.	8. Date of Bi (Month, Di 10/8/1	ay, Yea	r)	Birthplac Country	,
	and w		Usual Residence of 10a. State	Decedent 10b, County		10c. City,	Town or	Location			, , ,			10d	. Inside City Limits
	Maryla f sho ied at	tor	MD	BALTIMO	RE:	TOW	SON								1 □Yes 2 □XNo
	r 28a-	Director	10e. Street and Num			10	2011	10f. Zip Code				10g. C	Citizen of Wha	it Country	?
	ath wit 23a c ust be		816 MOCK	INGBIRD I				21286					JSA		
980	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed		Armond Cornes?	Was Decedent Ever in U.S. Armed Forces?  I 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 1 No Specify:  I □ Yes 2 1 No Specify:				pecify Yes or Note Rican, etc.)	0-	14. Race - Black, Specify:	American White, etc Whi	).	
Maryland 21215-0036	within 72 ho ene. <b>than "natur</b> te Medical I	Completed	Elementary/Secon		ducation		(Gir life	cedent's Usual Occu ve kind of work done . DO NOT use retire OUNTANT	during	most of wo	rking	MD	Kind of Busin SHIP I DOCK	BUILE	•
d 2	filed v Hygic other t		12TH GR 17. Father's Name (		)		ACC	OOIVIAIVI	18. M	lother's Na	me (First, Middle	, Maide	en Surname)		
/lan	Jental Jental rked c	To Be	HARRY I	. ROGERS	, SR.					RHODA	DEARHO	LT			
lary	S S S		19a. Informant's Na	me/Relationship (	Type. Print)		19b. Ma	iling Address (Stree	t and Nu	umberorR			or Town, Sta	ate, Zip C	
as a	1 and 2 Health em 27 i		ANNE D.		IFE	20b. Pl		MOCKINGE position (Name of	IRD	LANE	APT. 2		TOWSOI Location - Cit	_	
Baltimore,	permit. Pages 1 al Department of Hes Important: If item any Injury or othe		1 🕅 Bunal 2 [ 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other ( <i>Specil</i>	• • • • • • • • • • • • • • • • • • • •	DUL	Metery, c. ANEY DENS	rematory or other pla VALLEY MI	ΞM.		3/2008	coc	CKEYSV	LLE,	MD
Ball	permit Depart Import any In		21. Signature of Fu				- 8	22. Name and Addr 8521 LOCH	RAV	EN BL	VD. TO	WSO	FUNERA N, MD	AL HC 2128	OME, P.A. 36
			23a. Part1. Enter the shock, or hear	he disease, or com rt failure. List only	plications that caused one cause on each li	the death	. Do not e	enter the mode of dy	ing, suc	h as cardia	c or respiratory	arrest,		l Ir	Approximate nterval Between Onset and Death
j.	Physician		Immediate Cause ( disease or condition resulting in death)	Final n	_a			RY DISE	ASE						
	/Medical Examiner		roodking in doddin		Due to (or as			ART FAI	_URI						
	* 5%	Jer	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, nmediate	b. Due to (or as	a consequ	ence of):								
11	cuted nd transit	Examiner	that initiated events		C										
68760 <sub>x</sub>	icate be executed physician and s the burial-transit		resulting in death) t	asi	Due to (or as	a consequ	ence of):								
387	ficate   physi	edical			d										
.O. Box (	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death :	3□Ectopic pregnan 5□ Other <i>(sp</i> ec <i>ify)</i>	су				23d. Date of Month	-	ay Year
<u>α</u>	s that t ned by e detai	by Ph	Part II. Other signif	ficant conditions	contributing to death b	ut not resu	Iting in the	underlying cause g	iven in F	Part I.	23e. Did	tobacc	o use contrib	ute to the	cause of death?
ords	w requires been sign should be		CHRO	NIC OBS	TRUCTIVE	PUL	MONA	RY DISE	ASE		1 🗆	Yes	2□ No 3	☐ Probab	oly 4 Unknown
Il Records,	hysician: The law ru his certificate has be I director, page 2 sh	Completed	CHRO	NIC REN	AL FAILU	RE			4 = 1		24a. Wa aut per 1∐ Yes	s an opsy formed 2	pride	or to comp	y findings available pletion of cause of No
Vital	Physician: r this certifica ral director, I	Be	25. Was case refer examiner?	f	Hospital: 🐪				her		ath (Check only				
ō	<u>a</u> + a	. To	1 ☐ Yes 2 27. Manner of Deat		28a. Date of Inju	ıry	ER/Outpat 28b. Time	e of 28c. Inj	4 L	Nursing	Home 5 ☐ Res 28d. Describe				
ion	Attending Phradestrian After the ector: After the by the funeral	ation	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	y Year)	lnjur		ork? ] Yes	2 □ No					
Division	l or Atten after deatl Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inj building, et	ury - At ho tc. (Specify	me, farm,	street, factory, office	9		28f. Location City or T			o <i>r Rur</i> ai I	Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	of examinat									
	To the Within To the	Me	29b. Signature and	litle of certifie				29c. Licer	nse num	ber		29d. I	Date signed (	Month, D	ay, Year)
			1	In	^			D4	635	6		M	Pr. 1 /	61.	2008
	all				completed cause of c				79* 1 1	olpm som	1.100.000.00.00.00.00.00	/ C PT C	1 1 1 1 1 1 1 1	and the same of	7h /.
	178		31 Date filed (Mon	W TABAS	2. Registr			SLER DR	IVE	TO	WSON, M	HKY	LAND	2120	4
	Sta Regist		AF	R 2 1 200	82. Registr	1 15	1	are							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate this

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

'natural",

al Hygiene.

other traumatic event, the Medical

burial-trar and the as use for 1 detached page 2 funeral director. death.

Hospital or Attending n 24 hours after death.

In Funeral Director: A sletely filled in by the filled completely within 2

6×

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

Medical

State Registrar DHMH 17 Rev 1/2001



and manner stated.

**ORIGINAL** 

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

-aure

29d. Date signed (Month. Dav. Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:30 M ellers 04 16 2009 breen 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, 66 Cheverly George's Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1□M 2♥F 1/20/1964 Washington D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 005 20774 Hobart Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government ecretary 12 yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) reen Iberta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hobart St S pringdale Verome Dellers 2nd Husband 20174 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4/24/2008 Suitland 4 □ Donation 5 □ Other (Specify) incoln Memo 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility 814 Upshur St N.W TRI-State Funeral Services Washington DC w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of) Lelli beter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 125 Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 🕱 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? /es 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 📈 inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

requires that the death certificate be executed physician and s the burial-trans Box 68760, attending p for use as as P.0. the by 1 signed by Division or Vital Records, been si should I has page 2 certificate this After t or Attending within 24 hours after death. To the Funeral Director; A

the Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

la or 28a-f show t be notified at

23a

"natural", or

Examiner

traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other tra once.

**Physician** /Medical

Examiner

Examiner

Physician/Medical

2

Be

٩

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and tixe

and Mental Hygiene.

Pages 1 and 2 should be

of Health

Director

Funeral

Q Q

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2 Accident 6 ☐ Could not be 3 Suicide 4 THomicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

and manner stated.

heverly.

State Registrar

5

31. Date filed (Month, Day, Year) APR 2 1 2008

lacous

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician THOMAS Ε. SANDERS 40KI 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genera altime Jak ylana Hospital N/A If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) In yrs. last birthday, **Funeral** 6. Sex 7. Age Min. Hours Months Days XXM 2□ F Director 239-54-8237 72 5 1936 NORTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "netural", or itema 23s or traumatic avant, the Medical Exerting Institut by U.S.A. 411 GWYNN AVENUE Funerai 21229 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 Married 1 Yes 2 X No Specify: þ Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF 12yrs BARBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OLIVER SANDERS ELLA TROTTER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 Itam 27 I Thelma D. Sanders/Wife 411 Gwynn Avenue, Baltimore, Maryland 21229 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 04-21-08 BALTIMORE, MARYLAND Balti 21. Sign du e of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. arbara wun 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death netas Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 4Stimal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ng physicien as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed r24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 1 4. Inpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter agour.
To the Funerel Director: All 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

M.D. 300 32 Registrar's Signature.

ANENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day 2008 **Physician** 19 3:45 PM M Schmitt April Lawrence Paul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrest Center for Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 212 42 1868 65 Sept 9,1942 Director Balto., Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 ☐Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 541 S. Marlyn Avenue 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Tavern 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence L. Schmitt Evelyn Chesser ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Schmitt (wife) 541 S. Marlyn Avenue Essex Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory Inc 4/23/2008 Baltimre Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA nature of Fun ral Se vice License 1407 Old Eastern Avenue Essex Maryland 21221 23a. Fart 1 Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) ANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Tyes 2 No g  $\square$  Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> LSEASS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 🗆 No 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textsquare Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Jeath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending 1 □Yes 2 □No

certificate be executed Box 68760, P.O. 1 Records, of Vital or Attending Physician: Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu

28a-f show

27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Ever a nust be not the 12

filed withir Hygiene.

2 should be find and Mental H

Department of Health a Important: If item 27 is any injury or other trat

burial-transi and

ing physician a s as the burial-

attending p

signed by the a

been

has page 2 s

certificate

director,

After this c funeral din

death.

Pages 1

Baltimore, Maryland 21215-0036

1 Natural 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier (Check only one)

29b. Signature and title of certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555W. Towsetown Blud/Belto MD 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 2008 2:45 am Robert B. Staines 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Manor Care Rossville Rosedale Baltimore if Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06-04-1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1**⊠** M 2□ F Maryland 74 212-28-1529 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State N/A Maryland Baltimore 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 U.S.A. 6014 Old Harford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Korea Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eastern Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Stainless Steel 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Troyer Walter Staines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6014 Old Harford Road Baltimore, Maryland 21214 Mrs. Charlotte V. Staines - Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 04/21/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun val Swee Licensee 5305 Harford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cau (Final disease or condition resulting in deeth) ASCU D Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

Director

Funeral

þ

Completed

Be

ပ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be in

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the buria signed by t page 2 certificate

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after voc....
To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,

Part il. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part i.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknow
				24a. Was en autopsy performed?   24b. Were autopsy findings availat prior to completion of cause o death?   1
25. Was case referred to medical			26. Place of De	eath (Check only one)
examiner? 1  Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatient 3 🗆 🛭	OCA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner Death 1 1 atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not 1 determined		me, farm, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
				ace, and due to the cause(s) and manner as stated.  ccurred at the time, date and place, and due to the cause(s)

10

State Registrar

057727 Wortham Woods

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

31. Date filed (Month, Day, Year) APR 21 2008

29b. Signature and title of certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:16 A.M 18 2008 Anna C. Samuelson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TIMORE N/A GNE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 11/14/1921 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Maryland 1 ☐ M 2 🔀 F Yrs 86 213-12-8123 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 Completed by Funeral 4740 Homesdale Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Office Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Wayson Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 4722 Homesdale Avenue, Baltimore, MD 21206 Karen Smith, Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 04/21/08 Baltimore, MD 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses Baltimore. 5305 Harford Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Vascular Unknown **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner ig physician and as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical ed by the attending person of the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an Hypertension autopsy performed? Yes 2 2 No 1[7] Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check onl o Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 2 ER/Outpatient 3 DOA To 1 🔲 Inpatient After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Z Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

CANA,

SAMUELSON

Agner / to sp. 79/ 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Bergeon

filed (Month, Day, Year) APR 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02675 State of Maryland / Department of Health and Mental Hygiene Steve Robert Snyder 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ April 5, 2008 Robert Snyder Steven **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County Baltimore** 1312 Highland Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY), 9. Birthplace (State or 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Foreign Country) Months Days Hours Min. 1981 10 11 Director 26 299-80-3396 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Avon Lake , or items 23a or 28a-f show must be notified at once. Ohio 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 44012 32282 Pinehurst Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White Yes, Give Year Yes 2 X No specify: 3 Widowed 4 Divorced it. Pages 1 and 2 should be filed within 72 hours after travent of Health and Mental Hygiene. rrtant: If item 27 is marked other than "natural", y or other traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) N/A student 2 yrs 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Snyder Steffy Aaron Kaye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 32282 Pinehurst Dr. Avon Lake, Ohio 44012 Snyder-father Aaron 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Greenmount Crematbry4/8/08 Baltimore 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Avenue Baltimore, E.North la. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Medical Fentanyl intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial -##F,25a,27,28a-f, per ME,g879, 5/6/08 TT 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ð ₫. Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes certificate h 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other: Hospital: examiner? Nursing Home 5 Residence 6 V Other: Scene 2 ER/Outpatient 3 DOA Inpatient this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death

1051 hrs

10d. Inside City Limits

1 Yes 2 No

MD

21202

Approximate Interval

Between Onset and

Death

Year

2 No

MD

the Hospital or Attending Physician: thin 24 hours after death. Natural Yes 2 X No Pending unk Fnd 10:30 am Director: Fnd 4/5/2008 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 6 X Could not be 3 or Town, State)
1312 Highland Dr. Baltimore, MD Suicide determined (Specify) group home Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca To the ] and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier April 6, 2008 O.C.M.E. llai 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

OCME

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2008 Robert Sprouse, Jr. April 14, 1:45 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov 4, 1944 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Virginia 63 579 54 6798 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XXVo Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7609 Earn Shaw Drive 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1, TyYes 2 □ No IFYes, Give Year or Dates: 1 Never Married AMMarried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Health Benefits Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Sprouse, Sr. Celia V. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Sprouse(Wife) 7609 Earn Shaw Drive, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 21, 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Persit Lo Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION ACUTE MYOCIARDIAL Due to (or as a consequence of): ARTERLY CORONARY Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 Onknown HYPERTEWSION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? LUNG CANCER 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, attending p for use as t or Attending Physician:

Physician/Medical IF FEMALE: Certification: To

Completed by Be

Examine

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

à

Completed

Be

ဥ

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death. after death in by 1 within 24 hours a

To the Funeral I

completely filled

12+1

29b. Signature and title of certifier

JODRIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only

JOBRIG, MD

APR 2 1 2008

7503 SURRATTS ROAD, CLINTON, MARYLAND 32. Registrar's Signature

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D40324

29d. Date signed (Month, Day, Year)

APRIL 14, 2008

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sidner **Physician** APRIL 2008 10:30A M 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institut on, give street and number) **Examiner** BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE Date of Birth (Month, Day, Year) 10/01/1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours MD 94 212-07-3900 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examinar nast be notified at 1 □Yes 2 No Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō illed within 72 hours after death with USA or items 23a 5 PLEASANT RIDGE DRIVE, #407 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Dives 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ XNo ş 3 Nidowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) OWNER JACKS POULTRY is 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SINDLER FANNIE FRIEDMAN HARRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 127 WARREN AVENUE, BALTIMORE, MD GARY SINDLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/18/2008 BALTIMORE, MD HEBREW YOUNG MEN 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** um disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cutos. Enter or darrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Year) 32. Registrar's Signature State APR 2 Registrar

		1 - For State Registrar	State of Ma	aryiano /	•	tificate of		na iviei	,	giene Reg. No.	2000	1000
Physic /Med		Decedent's Name (First, Middle, Later JOHN	st)			SATTA	1	2.	. Date of Dea Month APRIL	Day	5 2008	3. Time of Death  12:45P M
Exam		4a. Facility Name (If not institution, given MANORCARE HEALT	TH SERVICE:			4b. City, Town, o	N			BA	ounty of Death	
Funera Directo		5. Social Security Number 6. S 045-24-4386 1 Usual Residence of Decedent	ex 7. Agr XM 2□F	e (In yrs. last b	irthday) Yrs.	if Under 1 Year Months Days		4 Hrs. 8. Min.	(Month, Da	y, Year) 1930	Coun	ace (State or Foreign try) NY
e Maryland 3a-f show tifled at	Director	10a. State 10b. County  MD BALTIMO	)RE	10c. City, Tov	vn or Loc	cation					10	0d. Inside City Limits 1
ath with th 23a or 26 Lust be no	ral Dire	10e. Street and Number 509 E. JOPPA RO					286				en of What Coun	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces?  1 MYes 2 1 MYes, Give Year or Dates:	No	1	Vas Decedent of I f Yes, specify Cub ☐ Yes 21 No	Specify:	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	s		HITE
21215-0036 Id within 72 hours af Igiene. In the medical Exami In the Medical Exami	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5 5+		a. Deced (Give : life. £	lent's Usual Occup kind of work done OO NOT use retire ATTORN	during most o	of working		16b. Kind	of Business/Ind	,
Maryland 2 d 2 should be filed tht and Mental Hyg 7 Is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last, SALVATORE	)	,	SATT	-A		s Name (F	First, Middle,	Maiden Si	,	LLITTU
t, Maryla and 2 should eath and Mer no 27 Is marke ter traumatic		19a. Informant's Name/Relationship (		3	300	g Address (Street GIBBONS		, B/	ALTIMO			
altimore, mit. Pages 1 a partment of Hee portant: If Item y Injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		20b. Place cemet	ory, cren	sition (Name of natory or other pla ERVICE (	ORP. 0		/2008	TOV	ation - City or To	
Balt permit. Depart Imports any Inju		21 Signature of Funeral Service Licer	Hemi		_ 8		STERSTO	WN R	0AD -	PIKES	& BROS., SVILLE,	MD 21208
Physiciar /Medica	-	23 Pr.11. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pherm	0119		er the mode of dyi	ng, such as ca	ardiac or r	espiratory ar	rrest,		Approximate Interval Between Onset and Death
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequence								
68760, tificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause Chicago of High that initiated events resulting in death) Last	cDue to (or as	a consequence	of):							
	Medical	IE ESMALS.	d,									
Vital Records, P.O. Box slclan: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pregnand Other (specify) _	у			23	d. Date of delive Month	ry Day Year
ords, P equires that en signed b ould be deta	ed by Ph	Part II. Other significant conditions of	contributing to death b	ut not resulting	in the ur	nderlying cause gi	ven in Part I.		23e. Did to		_	e cause of death? ably 4 ∐Unknown
al Recc : The law racate has be cate has be	Completed							_	24a. Was autop perfo 1∐ Yes		24b. Were autoprior to condeath?	osy findings available inpletion of cause of
/ita	Be	25. Was case referred to medical examiner?	I I a a sida la			Tau		of Death (C	Check only o	ne)		
hysl this c	ျ	1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatie			· OLI DOX		sing Home	5 ☐ Resid	dence 6	☐Other (Specify	)
Division or Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not b			Time of Injury	M 1	ryat rk? ]Yes 2∐No		d. Describe I	how injury	occurred	
DIVI	Certific	4 Homicide determined	building, et	c. (Specify)					City or Tov	vn, State)	Number or Rura	
the Hosp nin 24 hou the Fune	Medical	(Check only one)	nysician: To the best niner: On the basis o and manner sta	f examination a	ge, death und/or inv	vestigation, in my	opinion, death	place, and n occurred	I at the time,	date and p	olace, and due to	the cause(s)
To with	2	29b. Signature and title of certifier					61199				signed (Month, 1	
1		30. Name and address of person who Jason Black 65	65 North 1	Charles	(Type,	Scite.	209. 7	Tous	or. m	0 2	1204	
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 1	2008 32. Refistr	ar's Signature		new						
DHMH 17 Rev 1	/2001	• •	The state of the s		-	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 98/8 4-21-08 vt. State of Maryland P Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** 3:10 PM Manette Manalang Villamor Apr 14, 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner **Baltimroe** Catonsville Paradise Assisited Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. State or Foreign 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Phylipines
Phylipines
Philippi Funeral Hours Months Days Min 1 □ M 2 ▼ F Director 86 397-16-1611 Dec 1, 1921 Usual Residence of Decedent the Maryland 10d. Inside City Limits, 10a, State 10b. County 10c. City, Town or Location 28a-f show ar than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Catonsville MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Heme any Injury or other trainment. 6348 Frederick Rd. 21228 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ ¥es 2 No Specify Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ception llemca 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cristobal Manalang Helen Cook ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9757 Owen Brown Rd. Columbia, MD 21045 Sally Villamor Daughter-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State S EDISCOPUL Church 4-18-08 22. Name and Address of Facility 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Hun willer Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SENIE Dementia /Medical Due to (or as a consequence of): Examiner PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine OEdimiA MUPRRLI burial-tran Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 □ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? res 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes Nursing Home 5 Residence 6 Other (Specify) P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Ccident 5 Pending investigation 1 Yes 2 No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of confiden 29d. Date signed (Month, Day, Year) 29c. License number April 15, 2008,

Registrar
DHMH 17 Rev 1/2001

State

5450 Knoll worth DV. Suite 260 Colombia MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAWA

Year)

31. Date filed (Month, Day,

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** Ruth Webber 2:10 P M Gertrude April 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale Manor Care - Rossville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | January 6, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖔 F 94 Massachusetts Director 220-46-6075 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages I and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2X No Director Maryland Rosedale Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8420 Avery Road 21237 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 years Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Wiggett Hattie Beach ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8420 Avery Road, Rosedale, Maryland 21237 James Webber son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 19 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 Donation 5 Dother (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. bo not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

the death certificate be executed attending physician and for use as the burial-tran been signed by the should be detached The law requires that has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

28a-f show

		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?   1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in the basis of examination and/or investigation and the basis of examination and the b	

29c. License number

Entow

29d. Date signed (Month, Day, Year)

Inte 301

BALTIMORE

M172164

cal

31. Date filed (Month, Day, Year) State

APR 21

29b. Signature and title of certifier

1 Jun 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

N

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "rany injury or other traumatic event, It a Neal any injury or other traumatic event, It a Neal Since.

Physician

/Medical

and the burial-tran

physician

attending pl

cate has been signed by the page 2 should be detached

certificate

this

After

after death.

Director: Af

within 24 hours a To the Funeral C

the

funeral director,

filled in by

the Maryland

death with

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

AMON J. CHAMIRES

APR 2 1 2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 21 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Philp

Wisotsky, MD 12070 Old Line Centre #207, Waldorf, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per fly 8878 4-21-08 yt.
State of Maryland / Bepartment of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Patrick K. Walker Apr 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard **Ellicott City** 3218 West Springs Dr. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 M 2 □ F Days MD **Director** 216-60-6915 2008 May 3, 1953 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director **Ellicott City** Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 3218 West Springs Dr. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Department of Health and Santal Hyglene. The marked other than "naturnalic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Carpenter U17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Albert Walker Sr. Virgie Marie Atkins ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3218 West Springs Dr. Ellicott City, MD 21043 Lillian Cross 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Burial 2 ☐Cremation 3 ☐Removal from State Apr 17, 2008 Ellicott City, Maryland Good Shepherd Cemetery Signature of Funeral Service Licen ee 22. Name and Address of Facility 71 Did Columbia Slack Funeral Home, P.A. 21043 , md 23a. Part1. Enter the debase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** head cance + neac 40003 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 1 □Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has the lirector, page 2 s 24a. Was an autopsy 1☐ Yes the Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DO 57936 04-15-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 57 Bail how 7, Mb 21201

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

BRUKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 15 per fb 9878 4-19-08 lth and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ALLEN **Physician** ARREN 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMURE BALTIMORE REHABILITATION EXTENDED CARE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 64 212-42-5706 Usual Residence of Decede 11/07/1943 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 Canterbury Road 21234 USA 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Stres 2 □ No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Commercial 12 Tradesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any Injury or other traumatic ev ဥ Warren Allen White, Sr. Caroline Welsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Kelly Barnstein/Daughter 2514 Canterbury Road Parkville, MD 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 19 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory
22. Name and Address of Facility 2008 Beltsville, Maryland Inc. 21. Signature of Funeral Service Licenses Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

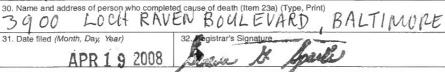
a. CANCER ESOPHAGUS Maryland 21266 Interval Between Onset and Death **Physician** DNE YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? Month Day Year signed by the at d be detached for 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

5+1

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier,



29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 88/8 4-21-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Des 1. Decedent's Name (First, Middle, Last) Month 3 Year Eatha Zendt **Physician** Zachha 31 1000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Oak Crest Care Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, Jan. 2, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2X F PΑ Yrs. 1915 217-34-5168 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at 1 ☐Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ms 23a or r 21234 USA 8800 Walther Blvd. Funeral 14. Race - American Indian, nt of Health and Mental Hyglene.

If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ School Libriaian Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Newton Allebach Luella Blanck ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2308 Killoran Road, Timonium, MD. 21093 Linda Lieske (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Whitemarsh Mem. Park 04/04/2008 Prospectville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21 204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burlal-transli resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by uncontrolle 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winkhown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 10 Certification: To 28a. Date of Injury (Month, Day 28h Time of 27. Manner of Beath 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 15:19 1 **Physician** 19 APRIL 2008 ELUIRA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 8 1 M 2 F 5602 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No KESVILLE Director mo 10g. Citizen of What Country? 10e. Street and Number FERSON Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 Specify Specify: WHITE ⋧ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) ALCOA College (1-4 or 5+) al Hygiene. Elementary/Secondary (0-12) ALUMINUM ECRETARY Ö the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental marked ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) and I VEFFERSON AUC, Health tem 27 MARY LOW ZYRA DAUGHTER Important: If item 2 any injury or other once. 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō 4/23/2008 SYFESUILLE, MD permit. Page Department of SPRINGFIELD Cen 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J N ZUMBWN FH & MON G 199 ELDERSBURG NO 21784 6028 SYKESVILLE Roav 23a. Roft 1. Chief the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOURS ANOXIC BRAIN INJURY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hours *fulseless* Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of) 60, Solution of the executed Exami attending physician and d for use as the burial-transit DAKS SEPSIS that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760, DAYS ARREST Physician/Medical JENTRIGULAR IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ of Vital Records, 3 Probably 4 Unknown 2**X**No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical completely filled in by the funeral director, Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: after death. Director: After t 1 Natural
2 Accident 5 ☐ Pending investigation Division or Attending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifie 29c. License number -RES-0000 2008 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 TOHUS LEOPKINS HOSPITAL ZUBRISK A.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1	13	13	0	1	0	0	1	1
2	U	U	U	1	6	8		1

			For State		Certif	icate of	Death					eg. No.			//	
/ I P	Physicia Examin	ın/	. Decedent's Name (First, Middle,Last)  MARGARET	A. A	VERHA					N.	Date of Dea Month March 27	, 2008	Year		3. Time of 2152 h	
·.			la. Facility Name (if not institution, give s 3505 56th Street	treet and number)		4t	. City, Tov Hyattsv		cation of I	Death			County or rince G		's	
E	uneral	4	5. Social Security Number 6. Sex	7. Age (Ir	yrs. last	birthday)	If Under		if Under 2		B. Date of B	irth (MM/I	DD/YYYY)	9. Birt	hplace (Sta	te or Foreign
	irector		344-70-8811 1_N	A 2 ▼ X	34	Yrs.	Months	Days	Hours	Min.	Oct.	15 1	973		CAGO,	ILL
	any		Usual Residence of Decedent  10a. State 10b. County	100	c. City, To	wn or Locatio	on								10d. Inside	e City Limits
7	<b>*</b>		MD PRINCE G	EROGE'S		HYA'	TTSVI	LLE								2No
ne/vue,	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip C					10g. Citiz	en of Wh	at Cou	ntry?	
the A	23a or notified		3505 56th STREET			42 18/00		784	anic Origin	n2 / Speci	ify Yes or N	lo-	USA 14. Race	- Amer	can Indian,	Black,
5 77 hourse ofter death with the Maryland	death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 X	1	If Ye	es, specify	Cuban,	Mexican, F	Puerto Rio	can, etc.)		White			
- Page		by Fi		f Yes, Give Yeer or Dates:		1 6a. Decedent	Yes 2X			ind of wor	k done	16b k	Specify: (ind of Bu		BLACK	
9	led within 72 hours after Hygiene. tother than "natural", the Medical Examiner		15. Decedent's Education (Specify online Elementary/Secondary (0-12)	y highest grade comple College (1-4 or 5+)		during mo	st of worki	ng life. I	DO NOT u	se retired	d)	102.1	4110 01 22		,	ļ
36	within 72 giene. her than '	Completed	Elementary/occordary (5 12)	1 YR		CUSTO	MER S					1	RIVA'			
2-0(	filed within 72 I Hygiene. ed other than " t, the Medical		17. Father's Name (First, Middle, Last)  MTTCHEL AVERH	A D T				1	8.Mother's SUZA		irst, Middle ROCH		Surname	)		
21215-0036	ld be Aenta narke even	To Be	MITCHEL AVERH  19a. informant's Name/Relationship (Ty			19b. Mailing	Address	(Street	and Numb	ber or Rui	ral Route N	umber, C	ity or Tow	vn, Stat		
Q N	2 sho h and 27 is imati	_	SUZANNE ROCHON/MO			3505					SVILL Date	E, MA	RYLA	ND - City o	20784 Town, Sta	
re,	es l and of Healt If item ther trau		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	cre	ace of Dispos ematory or oth	ner place)		- 1						RYLANI	
Baltimore	permit. Page Department of Important: injury or otl		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	00 /	MD	NATIO	lame and A	Address	of Facility	3	J JE	NELL	SE	NEK.	ALC: HOL	Œ
Bal	permi Depar Impo injur	X. I	NIMA A LOOM	11106		7	474 I	AND	OVER	ROAD	LAND	OVER	,MAR	YLA.	ND 20.	/85
	ysician		23a. Part I. Enter the discusse, or complifications. List only one cause on each	cations that caused th	e death. D	o not enter t	he mode of	f dying,	such as ca	ardiac or r	respiratory a	arrest, sh	ock, or he	eart		mate Interval en Onset and Death
	Medical caminer		Immediate Cause (Final disease a.	ntracranial Hemo											10	
			Sequentially list conditions, b.	Due to (or as a conseq	dence 61).										+-	
		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):											
	rted d ansit	Examine		Due to (or as a conseq	uence of):											
	icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED												
760,	ficate b g physic the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	e of pregna	ancy	etal death	3	Ectopic	c pregnan	псу	2	3d. Date o Month	of delive	ery Day	Year
Box 687	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as t	Physician	past 12 months?  1 Yes 2 No 9 V Unknown	4 Pregnant at ti	me of dea	46	ther (Spec									
8	the deal y the all ched fo	Phys	Part II. Other significant conditions		but not re:	sulting in the	underlying	cause (	given in Pa	art I.					to the cause	_
P.O.	es that igned b	þ	Hypertension								3:					Unknown
rds,	law requir has been s 2 should t	Completed										utopsy	- 1	. Were prior to death	o completio	dings available n of cause of
oce	2 3	1 =		-							1 🗸 Y	erformed es 2	No	1 🗸		2 No
tal R	certific ector, p	Be C	25. Was case referred to medical examiner?	lospital: 1 Inpatier		ER/Outpatier		26.Place	of Death Other		only one) g Home 5	Resi	dence 6	<b>✓</b> Ot	ner: Scene	
Ž	Physic Per this eral dir	<u>P</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day,Ye		28b. Time of			ry at Worl		28d. Descr		njury occi	urred		
ono	ending ath. or: Af	tion	1 Natural 5 Pending 2 Accident Investigati		l			==	Yes 2							Nbas Cita
Division of Vital Records,	or Att after de Direct	i iii	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At ho	me, farm, str	eet, factory	, office	ouilding, e	etc.		on (Stree vn, State)		nber or	Rural Route	e Number, City
Ö	Hospital or 24 hours afte Funeral Dir tely filled in	Ser	4 Homicide determine 29a. Certifier (Check only 1 Certifying Physic	To the beat of my	knowledn	ie, death occ	urred at the	e time, d	ate and pl	lace, and	due to the	cause(s)	and manr	ner as s	tated.	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate by Completely filled in by the Kinneral director, page	Medical Certification:	(Check only one) 1 Certifying Physic one) 2 Medical Examine	r:On the basis of exame and manner stated.	nination ar	nd/or investig	ation, in m	y opinio	n, death o	ccurred a	t the time, o	ate and	prace, and	a age it	tile cause	
	E W E O	§	29b. Signature and title of certifier	(/ .)			29		se number .M.E.	r		- i	d. Date si Iarch 28		Month, Day 8	, rear)
0/			Mohne Dro	mell M	1	220)		0.0	.101					, _00		
1/1	10/	4	30. Name and address of rerson who Melissa Brassell, MD A	ssistant Medical	Examir	ner 111	Penn S	treet,	Baltimo	re, MD	21201					
		I. Stat	31. Date filed (Month, Day) 08	32. Registra	's Signati	and I										_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per inf 9879 5-5-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Robert Ralph Athey M April 12, 2008 17:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 12411 Stoneybrook Lane NW LaVale, Allegany If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex 1 XM 2 □ F Months Days Hours Min. 214-28-6777 75 April 4, 1933 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD LaVale 1 ☐ Yes 2√☐ No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12411 Stoneybrook Lane NW 21502 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 XX Yes 2 \( \) No
If Yes, Give
Year or Dates:

195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1951 1 Never Married 2 Married 1 □ Yes X□ No 1953 Specify: Specify 3 → Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Tire Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Webster Athey Mary (Martz) Athey 19p Noting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <del>10607</del> Beech Avenue SW, Cumberland, MD Karen Koontz 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Silbaugh Crematory Apr. 17 08 Uniontown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Hafer Funeral Service, 1302 National Hwy., LaVale, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on expiratory arrest, limited a Cause (Final Arteriosclerotic heart disease Arteriosclerotic heart disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy nerforme 1□ Yes 2√2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Department of H Important: If ite any injury or of

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours after death with the lent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a.

other traumatic event, the Medical

altimore, Maryland 21215-0036

Director

Completed by Funeral

Be Tot

Physician/Medical Examiner ng physician and as the burial-tran attending p ate has been signed by the a page 2 should be detached Completed by this certificate has l director, Be P funeral Certification: After filled in by the within 24 hours after death To the Funeral Director:

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician;

Hospitai

the

death.

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

25. Was case referred to medical examiner? 2□ No 27. Manner of Death

5 Pending investigation

6 Could not be determined

1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier (Check only

Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

D09157

29d. Date signed (Month, Day, Year) April 14 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and indress of person who completed cause of death (Item 23a) (Type, Print)

124 W Paul Snow, 3rd st Cumberland MD

State Registrar

Medical

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

**ORIGINAL** 

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea Month. **Physician** 2008 Anderson Marian Harriett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Lions Center for Rehabilitation Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birlh (Month, Day, Oct 21, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 ☐ F NY NY Director 577-32-0053 85 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at 1 Yes 2 No MD Cumberland Allegany by Funeral Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21502 USA 901 Seton Drive 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Specify Specify: 3 Widowed 4 □ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2+ homemaker own home permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Palty Evelyn Groggins Palty ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21520 2255 Sam Friend Road Accident Michael Anderson son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 4/14/2008 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Foneral 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** Corona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical signed by the attending p I be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 honths?
1 ☐ Yes 2 ☐ No 1 Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21 No Other: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To ours after death. neral Director; After this / filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10033280 April 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) austo الم

Registrar
DHMH 17 Rev 1/2001

DL

State

31. Date filed (Month, Day, Year)

APR 2

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	arylan		artment of I		and M		iene	008	12819
- Apr	Physici	an	1. Decedent's Name (First, Middle	, Last)						2. Date of Deat	h Day	Year	3. Time of Death
	/Medic		Iva	R.			Adkins			April	5	2008	00:13 M
	Examir	er	4a. Facility Name (If not institution	.//	n	201	4b. City, Town,	or Location of	of Death	′	4c. Co	ounty of Death	la.
			5. Social Security Number	7 10000	e (In vrs. )	last birthday)	If Under 1 Year	If Onder	24 Hrs. I	8. Date of Birth	4	9 Rirthr	lace (State or Foreign
	Funeral Director		220-12-1379	1 □ M 2X F	82	Yrs.	Months Days		Min.	(Month, Day, 9-27-19)		Cour	itry)
	p <sub>i</sub>		Usual Residence of Decedent							<u> </u>		Mary	
	arylar show d at	-	10a. State 10b. County			y, Town or Lo						1	0d. Inside City Limits 1 Y Yes 2 No
	he M	Director	MD Wicon	nico	Sa	alisbu	1			14	0.11		
	a or i		10e. Street and Number				10f. Zip Code	_		10		n of What Cour	ntry?
	ns 23 musi	Funeral	602 E. College	12. Was Decedent	Ever in U.:	S. 13.1	2180		igin? (Spe	cifv Yes or No-	USA 14.	Nace - Americ	an Indian,
က	or iter		1 ☐ Never Married 2 🔀 Marri	Armed Forces? ed 1 ☐ Yes 21			Vas Decedent of f Yes, specify Cul			Rican, etc.)		Black, White,	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notitled at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I∐Yes 2XX No	Specify:			Sp	pecify: Wh	ite
5-(	"natu	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during mos	t of worki	ng	16b. Kind	of Business/Inc	dustry
121	within iene. than " he Med	m d	Elementary/Secondary (0-12)	College (1-4or 5	5+)	_	amstress	ea)			То	extile	
<b>d</b> 2	filed Hygid other ent, th		17. Father's Name (First, Middle, I	Last)		560	imstress	18. Mothe	er's Name	(First, Middle, N			
<u>la</u> n	lid be lental ked c	To Be	Ira	Dennis				Edit	h		IInk	nown	
Maryland	2 should be and Menta is marked raumatic ev		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	g Address (Stree			l Route Number,			Code)
	r 27		Alton Adkins -	Husband			E. Colles	ge Ave	nue,	Salisbu	ıry,	MD 2180	)4
Baltimore,	(f) () h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	20b. P	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ace)	D	ate ;	20c. Locat	tion - City or To	own, State
ţ	permit. Page Department Important: If any injury or once.		4 □ Donation 5 □ Other (Sp	pecify)	Cre	matory	of Delm	arva	4-7-	2008_ 1	Delma	er, Dela	aware
Bal	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service	onsee 700		22	. Name and Addr	ess of Facili	bou:	nds Fune	eral	Home	
		$\vdash$	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death	h. Do not ent	05 E. Mar	ing Such as	eet,	Salisbu r respiratory arre	iry,	Marylar	nd 21804_ Approximate
	Dhysisian	2 1	Immediate Cause (Final	only one cause on each li	de.		hock		out wide o	. respiratory arre	.01,	8	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	Consequ	uence of):	NOCK	i	,				
	Examiner			h = -	50	chem	11/15	0(1)	e/				
	p #	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uerice of):	7	· ·	-				
	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	1as	cala	V D	1504	Se				
8760,	eath certificate be executed attending physician and for use as the burial-transit		,	Due to (or as	a consequ	derice oi):							
687	incate physis the	Physician/Medical		d	-								
Box (	death certific e attending p ed for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				23d	d. Date of delive	erv
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			]Ectopic pregnand ] Other <i>(specify)</i> _	у				Month	Day Year
P.O.	that the ed by th detache	hys	9 ☐ Unknown	9□Unknown						1			
	ires that the de signed by the a I be detached f	by	Part II. Other significant conditio	ns contributing to death b	ut not resu	ulting in the ur	iderlying cause gi	ven in Part I					ne cause of death?
Orc	law requires as been sign 2 should be	ted								1 ∐ Ye	s 2 l	No 3∐ Prob	ably 4 ∰Unknown
or Vital Records,	has b	Completed								24a. Was ar autops perforn	v I	prior to con	psy findings available mpletion of cause of
a	Tr ate pag		OF M			·				1□ Yes 2	2 Mo	death? 1 ☐ Yes	2 No
Ξ	Physician: The this certificate haral director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ant 2 🗆	ER/Outpatien	t 3DDOA Ot	her		(Check only one			
0	g Phys er this eral dii	n: To	27. Mann Pf Death	28a. Date of Inju	ry	28b. Time of				ne 5 Reside 8d. Describe ho			y)
ior	Attending r death. ector: After by the funer	atio	1	ation	y rear)	Injury		Yes 2	No				
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At ho c. (Specify	ome, farm, str	eet, factory, office		2	8f. Location (Sti	reet and N , State)	Number or Rura	I Route Number,
	oital ours aft			1					- 4				, v
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical	29a. Certifier 1	g Physician: To the best Examiner: On the basis o and manner sta	f examinat	wiedge, death tion and/or in	occurred at the tweety estigation, in my	ime, date ar opinion, dea	nd place, a ath occurr	and due to the ca ed at the time, da	ause(s) an ate and pl	nd manner as si lace, and due to	tated. the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mariner su	ateu.		29c. Licen	se number		29	d. Date s	signed (Month,	Day, Year)
	1		•	< Ke			1) 2:	22/2			4	171	28
/	79h	-	30. Name and address of person v	vho completed cause of d	eath (Item	1 23a) (Type,	Print)	NOV O			k	1 1/	-0
			Stephen Keim	mD 100 E.C.	ARMUL	11 st.	Print) SiAlisbu	Ry M	d.	21801			
	Sta		31. Date filed (Month, Day, Year)	32. Regetr	ar's Signat	ture	land.						
**	Registr	ar	MATER O	[ 2000	Suc	JO A							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10d 18 per inf, 23b,c, 23e per doc 9879 5-1-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 M March 0230 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4h. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Apr 03 1947 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months MD 60 Director 218-46-2953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov edical Examiner πust be notified at Yes 2016 Director Westminster Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 410 Leigh Masters Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary . Siegman Gottfried J. Beyer ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Leigh Masters Lane Westminster, MD 21158 Joyce Beyer/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/03/2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Leisters Church Cemetery Westminster, MD 21. Signatur Pritts Afterentaling Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the dis shock, or hear failu Immediate Care (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause in each line. **Physician** monte disease or condition resulting in death) /Medical Asthma Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Pulmonary Embolism and the burial-tra Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as t IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ξį in the past 12 months? Month 5 ☐ Other (specify) signed by the a P.0. ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 1 ☐ Yes 2 No obably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 1□ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 2 3□ DOA After this npatient ate of Injury funeral 28b. Time of 27. Manner of Dea 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) Injury Natural To the nospinal within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie License number WJL 10 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of G AFFAR M.D. STREE 0 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Roland Bernard Beck, Sr. April 2008 11:05p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1024 Highfield Drive Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**▼** M 2□ F 218-40-2295 Director 66 Feb 15, 1942 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □Yes 2↓ No Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 1024 Highfield Drive 21074 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No
If Yes, Give
Year or Dates:1961-64 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) grounds maintenance landscaping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i 1 and 2 should be fil Health and Mental H tem 27 Is marked oth William Adam Beck Florence Amanda Witcomb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 Highfield Drive, Hampstead, Md. 21074 Margaret Ann Beck, wife permit. Pages 1 an Department of Heal Important: If item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/7/2008 Injury or Garrison Forest Veterans Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MO0741 Eline Funeral Home any Lemmer Thanda 934 South Main St., Hampstead, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mir Non **Physician** /Medical Examiner Sequentially list conditions Due to for 25 Sconsequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed the burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical as the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? Division or Vital Records, by diseese 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy page certificate 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred medical examiner? 26. Place of Death (Check only ope) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 - Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL GTIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thatrew 00

State Registrar 31. Date filed (Month, Day, Year)

3

2008

APR 0

DHMH 17 Rev 1/2001

32. Restrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7:34 P M MARCH 30, 2008 CATHERINE BEASLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number 6. Sex 09-03-1916 Months Days Hours Min. 1 □ M 2 34 F 91 Orange, 578-16*-*0825 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Nes 2 No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 USA 909 Longfellow St., N.W. #106 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2版 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3 Nidowed 4 Divorced Black. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Supervisor Medical Supplies Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once. James Davis Louise Davis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Longfellow St., NW #106 Wash., DC 20011 Jacqueline O. Brooks/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 04-05-08 Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary Hidgman MO1374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Hon Q 'wave myocardial infarction Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hypotension Due to (or as a consequence of): Physician/Medical Leaking Thoracic aortic aneurysm IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 🔲 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 Matural

Examiner requires that the death certificate be executed and burial-trai Box 68760. the attending ph o signed by t ۵. Records, Jas page 2 certificate Division or Vital this Hospital or Attending

**Physician** 

/Medical

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

r than "natur the Medical

Hygiene.

2 should be fi

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification:

After t 24 hours after death e Funeral Director;

within 2 &C

Registrar

Medical

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Azeez Abiodun 31. Date filed (Month, Day, Year,

APR 0 7 2008

29b. Signature and title of certifie

6 ☐ Could not be

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

8118 Good Luck Road

and manner stated.

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

1 ☐ Yes 2 ☐ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 62810

Lanham, Maryland

28f. Location (Street and Number or Rural Route Number, City or Town, State)

03/31/2008

20706

29d. Date signed (Month, Day, Year)

3. Time of Death

Day

1. Decedent's Name (First, Middle, Last) **Physician** /Medical Examiner **Funeral** Director death with the Maryland 28a-f show Director MD ö Funeral or items permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner Baltimore, Maryland 21215-0036 þ Completed Be ပ **Physician** /Medical **Examiner** Examiner and Records, P.O. Box 68760 death certificate be

burial-transit physician To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: A ner

Division or Vital

2008 02:25 A M 02, April Lewis H. Bunker 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Wilson Health Care Center Gaithersburg 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 F Months | Days | Hours | M 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Hours 1 ▼M 2 □ F 89 158-10-7810 Yrs. Oct. 22,1918 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 211 Russell Ave. #33 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No 1943— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry
Federal Bureau of 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Agent Investigation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis LaForest Bunker Marguerite Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Marion Bunker (Wife) 211 Russell Ave. #33 Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition pril 2008 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metropolitan Crem. Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home ck Dr. Gaithersburg, urtio E.K 10 East Deer Park Dr. MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 X Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title April 2, 2008 30. Name and ad viss of person who completed cause of death (Item 23s) (Type, Print) Dr. John R. Melnick 911 Russell Ave. Gaithersburg, MD 20877

State Registrar 31. Date filed (Month, Day, Year)

APR

04

2008

+1

gistrar's Signature

08-02646 Franklin Busta		Please Type of int in Black Indelible Ink.  State of Dearyland / Department of Heat  Certificate of Dea	alth and Men			211	û8   282
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date Mont	of Death		3. Time of Death
Medical Examin	ner	Franklin Lee Busta		April	4, 2008	<u> </u>	0504 hrs
			y, Town, or Location isbury	of Death		4c. County of Dea Wicomico	th
Funeral Director			nder 1 Year If Und nths Days Hour	n Adim	e of Birth (M	Fore	irthplace (State or eign country) MD
how any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           MD         Wicomico	Salisbur	У			10d. Inside City Limits 1 X Yes 2 No
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. 2 415 Truitt Street	Zip Code 21804		10g. 0	Citizen of What Co	•
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Mary tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-r other traumatic event, the Medical Examiner must be notified at	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spe	edent of Hispanic Ori ecify Cuban, Mexicar	n, Puerto Ricán, e		White, etc.	erican Indian, Black, white
hours aften and and and and and and and and and an	<u>a</u>	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuduring most of the complete of the complet	2 No specify ual Occupation (Give working life. DO NOT	kind of work don	e 16t	Specify: b. Kind of Busines	
1036 vithin 72   ene. er than "	Completed	12	penter			constr	uction
1215-C be filed vental Hygi	Be	17. Father's Name (First, Middle, Last)  John Herbert Busta Sr.	Sy	er's Name (First, N 'lvia Wal	ter	,	
MD 21 12 should th and Mc 127 is ms umatic er	욘		ess (Street and Nullitt St.,			-	ite, Zip Code)
Baltimore, MD 21215-00; bemit: Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other it nijury or other traumatic event, the Me.		20a. Method of Disposition  1	ice)	Date 4/14/08		c. Location - City  Crapo,	
Baltir permit. 1 Departm Importa injury o		21. Signature of Funeral Service Licensee 22. Name a	and Address of Facili	THOMAS		ral Home	
Physician /Medical <sup>©</sup> xaminer		23a. Part/ Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on each line. Hypertensive Atherosclero Immediate Cause (Final disease or condition resulting in death)  a by Acute and Chronic Alcohol Due to (or as a consequence of):	de of dying, such as DLIC CARDIOV	cardiac or respira ASCULAT DI	tory arrest, Sea.Se C	shock or heart complicated	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated counts resulting in death). Let					
		d.	22/08 amb				
760, sate be exphysiciar he burial	Medic	IF FEMALE: 23c. If yes, outcome of pregnancy	.2/ W ann			23d. Date of deliv	ery
Box 68760, e death certificate be execounthe attending physician and ed for use as the burial - tra	ysician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal dea 5 Other (S		oic pregnancy		Month	Day Year
P.O. E es that the gigned by the generative detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in F	Part I. 23			to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execumithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Completed			1		prior t	
fital sician: is certif lirector,	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death	Nursing Home		sidence 6 Ot	ner:
of V ing Phy After th	n: To	27. Manner of Death  28a. Date of Injury (Month Day Year)  28b. Time of Injury	28c. Injury at Wo	rk? 28d. De		injury occurred	
VISION or Attendi	Certification:	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	1 Yes 2 tory, office building,	etc. 28f. Lo	cation (Stree		Rural Route Number, City
E Hospital		4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and p	place, and due to	he cause(s)	and manner as s	tated.
To the vithin To the complex	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.  29b. Signature and title of certifier	n my opinion, death of 29c. License numbe			place, and due to	
	~	Carol Lellar	O.C.M.E.			pril 5, 2008	
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street	et, Baltimore, M	D 21201			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

	Decedent's Name	e (First, Middle, L	ast)						<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of Death
ın	Dame	2 T.	Boxes	$\sim$					Lind	7 2	CY 6	0430 PM
al	4a Facility Name (III	f not institution, of	rive street and number	)		4b. City, Town, o	r Location o	of Death	11	. 4c. County	of Deal	th
er	Donles	10-1	^	11- 0	0 6	(00-1	· ala-	_		Dan	12	a. L
	5. Social Security N	La L	Sex 7. A	ge (In yrs. la	act hirthday	/) If Under 1 Year	If Under	24 Hrs T	8. Date of Birth	10	O Rid	hplace (State or Foreign
			1 M 2 □ F		Yrs.	Months Days	Hours	Min.	(Month, Day, \		Co	nuntry)
	219-07-7			87	110.				May 11,	1920	Ma	ryland
	Usual Residence of			140- 01-								Lacia de antido
	10a. State	10b. County		Toc. City,	, Town or L							10d. Inside City Limits
ᅙ	MED	Dorch	nester			Ca	mbrid	ge				ty∑Yes 2 No
rec	10e. Street and Nur	nber				10f. Zip Code			10	g. Citizen of	What Co	ountry?
	F25 C1.	enburn A					21.61	2		T.T.C.	7.	
era		enburn A	12. Was Deceden	Ever in 11 S	2 12	Was Danadant of L	2161		oifu Voo or No	US.		rican Indian.
Ë	11. Marital Status		Armed Forces	?	. 10.	. Was Decedent of F If Yes, specity Cub	an, Mexicar	, Puerto F	Rican, etc.)		ck, Whit	
γF	1 Never Marri		If Yes, Give	•		1 ☐ Yes 2X No	Specify:			Specif	y: wh	ite
d b	3 XWidowed	4 LI Divorced	Year or Dates:									
ete	(Spec	15. Decedent's	Education grade completed)		16a. Dece	edent's Usual Occup re kind of work done	ation durina mos:	t of workin	10	6b. Kind of B	usiness/	Industry
현	Elementary/Seco		College (1-4or	5+}	`life.	DO NOT use retire	d)					
Ö	7					waterman		_		se	afoc	od .
To Be Completed by Funeral Director	17. Father's Name (	(First, Middle, La	st)				18. Mothe	r's Name	(First, Middle, Ma	aiden Surnar	ne)	
8	Thomas	Brown					Est	telle	Travers	3		
Ĕ	19a. Informant's Na	ma/Balatianahia	(Time Print)		10b Mail	ling Addraga (Street					Cinta	Zin Codel
						ling Address (Street						zip Code)
			ghlin daug			7 Bonnie	<u>Brook</u>	<u>`</u>				1613
1	20a. Method of Disp		□ o	1 00	ace of Disp emetery, cre	oosition (Name of ematory or other pla	ce)	Da	ate 20	Oc. Location	- City or	Town, State
		Cremation 3 5	☐Removal from State cifv)	old	Trin	ity Churc	hvard	4/1	1/08	hurch	Cre	ek, MD
	21. Signature AFu					22. Name and Addre	_		mas Fune			
ŀ.	111	1500						1110				
_				-1.4510		700 Locus					1613	
	shock, or hea	ne disease, or co rt failure. List on	mplications that cause ly one cause on each	ed the death. line.	. Do not er	nter the mode of dyl	ng, such as	cardiac or	r respiratory arres	it,		Approximate Interval Between
9 7	Immediate Cause (	Final	nn	eii m	onia	2					ì	Onset and Death
	disease or condition resulting in death)  a. Dut to (or as a consequence of):											rucer
	Sequentially list conditions. b. /ymphoma /week											
F.	Sequentially list con if any, leading to im	nditions,	b. Due to or a:	s a consequ	ence of):							rucer
Ē	Cause. Enter Unde Cause (Disease or	nvinu										
xar	that initiated events resulting in death) L		c Due to (or a	s a consequi	ence of):							
ш			240 10 (01 4	o a conocqu	01,00 01,1							
cian/Medical Examiner			d									
Jec	IC CEMALE:									1		
2	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcom 1□Live birth			TEstonia programa	,			23d. Da	te of de	livery
	in the past 12 1 ☐ Yes 2 ☐	months?	4□Pregnant :			☐ Ectopic pregnanc ☐ Other (specify) _	у			Mo	onth	Day Year
ys	9 ☐ Unknown		9□Unknown									
Completed by Physi	Part II. Other signif	icant conditions	s contributing to death	but not resul	Iting in the	underlying cause giv	en in Part I.		23e. Did toba	cco use con	tribute to	the cause of death?
b			,		_		eral					robably 4 Minknown
ted		J	extery d	1300	-se,	parpri	1 50/		1 103		اء ال	- PACIFICALI
be	V250	cy. Kir	disease			·			24a. Was an autopsy	24b.	Were at	utopsy findings available completion of cause of
E		-							perform	ed?	death?	
Ö	25. Was case refer	red to medical					06 Plane	of Dooth			1 ∐ Yes	2 No
Be	examiner?	/	Hospital:			ant 317 DOA Oth	or.		(Check only one,			
۴	1 Yes 2 2		1 Inpat		28b. Time	BIIL SUIDOA	4 L INU		ne 5 Residen			cify)
ö	1 L Natural	5 Pending	28a. Date of Inj (Month, D		Injury	Wo	k?		8d. Describe hov	rinjury occur	rea	
äti	2 Accident	investigat	ha				Yes 2□	No				
Ĕ	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	Zoe. Flace of II	ijury - At hor	me, farm, s	street, factory, office		2	8f. Location (Stre City or Town,		ber or R	ural Route Number,
e		/	,	, -,,					<i>y = </i>	-/		
al (	29a. Certifier	1 Certifying	Physician: To the bes	t of my knov	wledge, dea	ath occurred at the ti	me, date ar	d place, a	and due to the car	use(s) and m	anner a	s stated.
Medical Certification: To	(Check only one)	2 Medical Ex	a <b>miner:</b> On the basis and manners		ion and/or i	investigation, in my	opinion, dea	th occurre	ed at the time, da	te and place,	and du	e to the cause(s)
Me	29b. Signature and	title of certifier				29c. Licens	e number		29	d. Date signe	ed (Moni	th, Day, Year)
-	00	2 1	1 1 201	)		11-	000	2-	,	11/0	6	)
	1 Dy	and the same	con ar	·		1400	12 9	14 /		7/0/	08	
	30. Name and addr	ess of person wh	no completed cause of	death (Item	//		N	2	ridge,		_	
	Patric	10 101	hnson	100	Bra	mble	Ca	mb	ridge,	MY	)	
te	31. Date filed (Mon.			Ar's Signat	ture	0						
ar		APR 0	9 2008	2000		angul s						
			400			1						

Sta Registr

()

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:55 P<sup>M</sup> Jane Bowen Apri1 2008 Betty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 ☐ M 2 🗓 F Director 220-28-5414 11-20-1930 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show be notified at Maryland Calvert Prince Frederick 1 ☐ Yes 2K No Director 10f. Zip Code 20678 10e. Street and Number 10g. Citizen of What Country?
United States 1550 Dan Bowen Road "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. white Specify: within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) oe filed wn. \*al Hygiene. \*a**r than "**pr Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 ages 1 and 2 should be filed wi ent of Health and Mental Hygier nt: If Item 27 Is marked other th y or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname)
Frances Hutchins 17. Father's Name (First, Middle, Last) Be Irving Bowen ည 19a. Informant's Name/Relationship (Type. Print)
Raymond D. Bowen- spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1550 Dan Bowen Road Prince Frederick MD 20678 permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Asbury Cemetery April 8 2008 Barstow Maryland 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Attrevoscienotic Carelio Vascular disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Dighetes mellitus 1 Yes 2 No 3 Probably 4 Monknown Completed Cerebrovaswian Accident 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 death? 1 ☐ Yes 2 ☐ No Peniphenal 2 1 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

the

29b. Signature and title of certifier

5851-

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

Church ten

32. Registrar's Signature

29c. License number

GYAN

Road

D 50653

C

Decela

29d. Date signed (Month, Day, Year)

SURANA

4-4-2008

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 12827 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month O. & **Physician** 0550 M CONES RUMAN 4  $\Omega$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 12771374934 2 🗆 F Washington DC 73 577 46 4141 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at MD Annapolis Anne Arundel 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ USA 21401 853 Inverrary Court or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1♥ Yes 2 □ No If Yes, Give Vorce? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Korean Year or Dates Era Specify: ģ Specify: White 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Cottege (1-4or 5+) filed within Hygiene. 12 Public Safety Firefighter is 1 and 2 should be filed in the stand Mental Hygic Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Weitzel Irby T. Cones ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 3025 Porter St #31/Washington DC 20008 Tracy Sacks (daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4/3/08 Metropolitan Crematory Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Etineral Service Liga Advent Funeral & Cremation Services > Milanie Annapolis MD and Falls Church VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician L /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed burial-transit and resulting in death) Last Due to for as a consequence of Box 68760, physicien Physician/Medical as the attending p IF FEMALE 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the be detached the 9 Unknown 9 Unknown ģ The law requires that signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 12 Yes 2 No 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 2 No 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification To the Hospital or Attending 1-Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No hours after death uneral Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) the e 29c. License number 2 21438 d cause of death (Item 23a) (Type, Print) DEFENSE Haway Annapous MD21401 e and address of page 11 HA 1. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

4

		For State		State	of Mar	yland /					Mental H	ygier	ne	000	
		Registrar					Certi	ificate o	f Deat	th		Reg.	No.	UUt	1282
Physic	ian	Decedent's Name	(First, Middle,	Last)							Date of I     Month		Day	Year	3. Time of Death
/Medi	ical	BARBARA			ANN			COLEMA			MARCH	3		800	12:27 P <sup>N</sup>
Exami	ner	4a. Facility Name (If		_	,		4	lb. City, Towr		on of Death	1			y of Death	_
<u> </u>		LAUREL 5. Social Security Nu		IAL HOSP	_	In the land h	-interior	LAURI If Under 1 Ye		der 24 Hrs.	I . D		PRINC		ORGE'S
Funeral Director		578-04-57		o. sex 1 ☐ M 2 <b>X</b> ☐ F		in yrs. last b		Months Day			8. Date of E	Day, <i>Үе</i> г	ar)	Cour	place (State or Foreigntry)
Director		Usual Residence of [	Decedent		43	3					JULY	3 1	964	SOUTH	H'CAROLINA
yland now		10a. State	10b. County		10	Dc. City, To	wn or Loca	tion				-		1	Od. Inside City Limits
a-f sh	tor	MD E	PRINCE	GEORGE 'S	S	LAUR	REL								1 X Yes 2 □ No
or 28	Director	10e. Street and Num	iber					10f. Zip Code	9			10g.	Citizen of	What Cour	ntry?
arrer death with the Maryland or items 23a or 28a-f show miner must be notified at	a	15769 HA	AYNES R	COAD				2	20707				USA	A	
ems er mu	Funeral	11. Marital Status		12. Was De	ecedent Eve Forces?	r in U.S.	13. Wa	s Decedent o	f Hispanic (	Origin? (Sp	pecify Yes or No Rican, etc.)	10-		ce - Americ	
or it		1 ☐ Never Marrie		ed 1 Tyes	s 2 TNo			Yes 251			o moan, etc.)			ick, White,	etc. BLACK
ural"	d by	3 ☐ Widowed 4		Year or	Dates:			••					Specia	ry: 1	JLACK
"nat	Completed	(Specif		s Education grade completed	d)	16	a. Deceder (Give kir.	nt's Usual Oce and of work don NOT use ret	cupation ne during m	nost of worl	king	16b.	Kind of B	Business/Ind	dustry
with ene. than he M	μŽ	Elementary/Second		College	(1-4or 5+)								DDTI	I A m T	
Hygi ther ent, ti	ŭ	12th 17. Father's Name (F				<u> </u>	MIKEL	RENEUF	-	ther's Nam	ne (First, Middi	le Maid	PRIV		
ental ked c	To Be	RICHARD	SMIT	ŕ						EARL		EVE		1110)	
md M marl	F	19a. Informant's Nan				19	b. Mailing	Address (Stre	et and Nun		ral Route Num			State Zin	Cadal
illo 2 alth a 27 is rtrau		OTIS CO	)LEMAN/	HUSBAND							EL, MAR			, 3 <i>iaie, 2ip</i> 20707	Code)
perim rayes I and 2 should be filed within 72 hours after death with the Marylan Important if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo	sition		:	20b. Place	of Dispositi	on (Name of		ı ı	Date	20c.	Location	- City or To	own, State
nt: if		1 ☑ Burial 2 ☐ 4 ☐ Donation 5						tory or other p	· ' i	4/7/2	2008	T.T A	SHING	GTON,I	nc .
Sorta Sorta		21. Signature of Fun				<u></u>		lame and Add		1				-	AL HOME
e a m c		1/2	ranz	Annole	uch		74	74 LAN	DOVER		D LANDO				
N. Serverill		23a. Fart1. Enter the	e disease, or c	complications that	t caused the	e death. Do	not enter t	the mode of d	ying, such	as cardiac	or respiratory	arrest,			Approximate
hysician		Immediate Cause (Fi	inal			ROTIC	CARD	IOVASO	III.AR	DISEA	ASE			- 1	Interval Between Onset and Death
/Medical		resulting in death)	- 2	a	o (or as a co			20 1110	· C J-IZZIC	21011		_		_	
xaminer		A CONTRACTOR OF THE CONTRACTOR		PLUMO	DNARY	EMBOL	ISM								
	ner	Sequentially list conditions if any, leading to immodule cause. Enter Underly Cause (Disease or in	nediate	Due to	o (or as a co	nsequence	of):								
nd	Examiner	triat iriitiated events		c. HYPEH	RTENSI	ON									
ian a		resulting in death) La	st	Due to	o (or as a co	onsequence	e of):								
hysic the bi	dical			d											
ing p		IF FEMALE:											-		
ttend	ian/	23b. Was decedent p in the past 12 m		23c. If yes, o 1□Live	utcome pf p birth 2		h 3∐Eo	topic pregnar	ncy					te of delive	•
the a	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pre 9□Unk	gnant at tim known	e of death	5 □ O	ther (specify)					IVIC	onth	Day Year
ed by detac		Part II. Other signific	ant condition	s contributing to	death but no	nt resulting	in the unde	rlying cause a	iven in Par	41	220 Did	tobooo	. una nant	teibuita ta th	e cause of death?
signe d be	by	DIABETES				or resulting	in the unde	nying cause (	jiv <del>o</del> ii iii rai	t I.			2 <b>X</b> ] No		e cause or deatn? ably 4 ⊟Unknown
peen	Completed		111111111111111111111111111111111111111	OD IIII							1	1 65	241 INU	3   Proba	abiy 4
has ye 2 s	Id II	ASTHMA									24a. Wa:	psy		prior to con	psy findings available npletion of cause of
ficate r, pag											1□ Yes	ormed?	10	death? 1 □ Yes	<b>X</b> □ No
certii	Be	25. Was case referred examiner?		Hospital:	_				thor		h (Check only				
r this	<u>P</u>	1 ☐ Yes 2 ☐ No.	0	1 1	Inpatient e of Injury	2 A ER/O	utpatient Time of	3 DOA	4⊔1	7-	ome 5 Res				)
h. Afte fune	tion	1 🖾 Natural 2 🔲 Accident	5 ☐ Pending investigat	(Mo	nth, Day Ye		injury	28c. In W	ork? □Yes 2[		28d. Describe	now inj	ury occur	rea	
deat ctor	fica	3 Suicide	6 ☐ Could no determine	t ho	ce of injury -	At home, fa					28f Location	(Stroot	and Numb	or or Rumi	Route Number,
i Dir. d in t	Certification:	4 ☐ Homicide	gereimit!	build	ding, etc. (S	ipecify)	-	factory, offic			City or To	wn, Sta	te)	. or riural	TOURS MUITINGI,
hours Inera y fille		29a. Certifier 1		Physician: To th	ne best of m	y knowiedg	e, death oc	curred at the	time, date	and place.	and due to the	cause	s) and ma	anner as st	ated.
within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 one)	∐ Medical Ex	kaminer: On the	basis of exa nner stated.	amination a	nd/or inves	tigation, in my	opinion, d	eath occur	red at the time	, date a	nd place,	and due to	the cause(s)
To the	Me	29b. Signature and tit	le of certifier					29c. Lice	nse number	r		29d. D	ate signe	d (Month, L	Day, Year)
			_lam	-, m	D.			D00	60100				APR	IL 2.	2008

State Registrar 31. Date filed (Month, Day, Year)
APR 0 4 2003

TAHMINA K. AHMED M.D. 831 UNIVERSITY BLVD EAST SILVER SPRING, MARYLAND 20903 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760 il or Attending Physician: after death. To the Funeral Director: Hospital

Certification: ca

3 ☐ Suicide

4 Homicide

(Check only

Mudusor

Utl

State

29b. Signature and title of certifier

Raza

6 Could not be determined

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MDD 66166

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, MD 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ULFRED 195 /Medical DI 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hon HOPPUT olundia rough If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 7907863 1 □ M 2 🗗 Hours 9 Z Director Dec 31 1915 Pennsylvania Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Md. Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Pages 1 and 2 should be filed within 72 hours after death with 21044 5400 Vantage Point Road #412 United States ral", or items 23a Examiner must b by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify. White "natural", er than "natura", the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) **Emmett** Paxton Shields Amv Kilheffer Marion ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13451 Allnutt Lane, Highland, Md. Daniel C. Callow / Son 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any Injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 4/5/08 Alexandria, Va. 21. Signature Fune al Service Liou see 22. Name and Address of Facility
Muriel H. Barber Funeral Home M -00470 P. O. Box 5038, Laytonsville, Md. 20882 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, he sing to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year ed by the a detached f 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ Jete , 2 No 3 Probably 4 Unknown page 2 should Completed 1 🗌 Yes peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ို 1 ☐ Inpatient 2 R/Outpatient 3 DOA After this 28a. Date of Injury funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours are, ....
To the Funeral Director: Aff 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29c. License number

5755 Cedar Lane, Columbia, Md.

29d. Date signed (Month, Day, Year)

21044

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Martinez, M.D.

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 0 0 0

			1 - For State Registrar	State of N	naryland /		irtment of Hi tificate of L			giene Reg. No	400	18	12831
	Physic	ian	Decedent's Name (First, Middle						2. Date of De Month	eath Da	ıy Y	'ear	3. Time of Death
N. C.	/Medi		ERNEST LINWC  4a. Facility Name (If not institution				4b. City, Town, or	Logotion of Dooth	April 6	-	008 c. County of	Death	11:00 am
	Exami	ier	26271 W. Pear S	-	'/		Crisfie		l		Somer		
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. last i	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			9. Birthpl	ace (State or Foreign
	Director		215-38-2172	1 ☑ M 2 ☐ F	67	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da March 12	y, Year, 2, 19	) 11 N	Count	land
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10	Od. Inside City Limits
	should be filed within 72 hours after death with the Maryland dental Hygiene. marked other than "natural", or items 23a or 28a-f ehow matic event, the Modical Examiner must be notified at	Director	MD Somers	set		isfi∈							1 ☐ Yes 2X No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of Wh	at Count	try?
	ath w	īa	26271 W. Pear S				21817				USA		
	er de Rem	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	>-	14. Race - Black,	America White, e	
21215-0036	irs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 【XDivorced	ed 1 XYes 2 If Yes, Give Year or Dates		1	☐ Yes 2 No	Specify:			Specify:	Wh	ite
ğ	2 hou	Completed	15. Decedent	's Education	1701	a. Deced	ent's Usual Occupa	tion		16b. K	(ind of Busin		
2	thin 7 e.	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	(Give I	kind of work done d OO NOT use retired)	uring most of work	king				elligence
	filed wi Hygien other th	S	10			Lith	ographer				ency	<b>1</b> 11C	errigence
Ē	be fill d off	Be	17. Father's Name (First, Middle,	·				18. Mother's Nam			Sumame)		
$\frac{2}{5}$	nould I Mer narke	P	Ernest William						eth Mus				
Maryland	d 2 st th and 7 ien		19a. Informant's Name/Relations Steven Collins		100		g Address (Street a						
	ges 1 and 2 should it of Health and Mer if Item 27 ie marke or other traumatic		20a. Method of Disposition	(5011)					- Fayet Date		LITE, ocation - Cit		rgia 30214
Baltimore,	iit. Pages artment of ortant: if it njury or o		1 ☐ Burial 2 🏿 Cremation 4 ☐ Donation 5 ☐ Other (Si		Salis	ery, crem bury	ation (Name of atory or other place Cremator	y 4/8	/08		Lisbur		
Balt	permit. Page Department of Important: if any njury or once.		21. Signature of Eurera Service	Mul		22. Br	Name and Address	Sons Fu	neral H	ome			
				adshaw, or.	d the death D	30	06 W. Mair	n Street	. Crisf	ield	, MD	2181	
ļ.	<b>-</b>		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each									Approximate Interval Between Onset and Death
į.	Physician /Medical		disease or condition resulting in death)	a. 1420	te C	ere	lioval L	cele	even	+			Cohpers
ĺ,	Examiner			Due to (or a	s a consequence	e of):	Dionor L	D.i.					7/54
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence	e of):	VI Rey	1000					yeu
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a lly	ise Le	en (	e					1	715 yeur
Š	e exe ien ar urial-t		resulting in death) Last	Due to (of a	a consequence	e of):							
09/89	tificate be executed in physicien and as the burial-transit	edicai		d								1	
_			IF FEMALE:	230 Hugs outcom									
ô	death cert e attendin d for use	Physician/N	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 □Fetat deat at time of death		Ectopic pregnancy Other (specify)				23d. Date o Month		y Day Year
j.		hys	1	9□ Unknown									
ν, L	requires that the een signed by th hould be detache	by P	Part II. Other significant conditio	ns contributing to death I	but not resulting	in the un	derlying cause giver	n in Part I.	23e. Did to	obacco i	use contribu	ite to the	cause of death?
cord	w require been si should I	ted	Diabettes	2					101	Yes 2	□ No 3[	Proba	bly 4 Unknown
Œ)	s b	Completed	Dyslipid	lemia					24a. Was autop	an	24b. Wer	re autop	sy findings available
ř	sician: The la certificate ha irector, page (	Sol							perfo	rmed? 2 No	dea	th? Yes 2	•
N I I I	ictan certifi ector	Be	25. Was case referred to medical examiner?	Massitali				26. Place of Deatl	h Check only o	ne			
õ	Phys this al dir	٦.	1 ☐ Yes 2 No  27. Manner of Death	Hospital:			3□ DOA Other	4   Nursing no				(Specify)	
0	Attending Physician: r death. ector: Atter this certific by the funeral director.	tol	1 Natural 5 Pending 2 Accident investig		y Year)	Time of Injury	28c. Injury : Work? M 1 7	at P es 2 No	28d. Describe h	now injui	ry occurred		
VISION	Attendi r death. ector: A by the fu	Ilica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of In	jury - At home, f	farm, stre			28f. Location (S	Street an	d Number o	or Rural	Route Number
5	ital or irs afte ral Dire	Certification;	4 [] Nomicide	building, e	tc. (Specify)				City or Tou	vn, State	)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1X Certifying (Check only one)	Physician: To the best xaminer. On the basis of and manner st	и вхапипалоп а	ge, death na/or inve	occurred at the time estigation, in my opi	, date and place, nion, death occurr	and due to the dred at the time, or	cause(s) date and	and manne d place, and	er as sta I due to t	ted. the cause(s)
	To the Tro the Comp	2	29b. Signature and title of certifier	2 220			29c. License	number		29d. Da	te signed (A	Aonth, D	ay, Year)
		ê	Il Hand	white a	~		200	0532	62	0	4/0	771	08
1+	-124		30. Name and address of person v	no completed cause of	death (Item 23a)	(Type, P	rint) P Jo	ha w	1. Hake	M	2 3	10	( )
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	k	hand .	بالا جاما	7,				2 1
	Registr	ar	APR -	8 2008	SELVED J	B /	7						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15° 2008<sup>ar</sup> Boon He Cho April 1 1:30P. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 93 Days Months Hours March 10, 1915 Seouty Korea 218-06-9475 1 ☐ M 2 🕱 F Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 Korea 11805 Wondering Oak Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lin Kim Kyung Suk Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 3204 Ashy Way Drexel Hill, Pennsylvania 19026 Sue Kim -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 4/18/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Ischemia **Physician** /Medical Due to (or as a consequence of): Examiner Cardiogenic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trans Acute Renal Failure Due to (or as a consequence of): attending physician for use as the hirrial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2XNo 2

No

No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 □ No Il Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D064760 April 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mythily Vancha, M.D. LRH 7300 Van Dusen Road Laurel, Maryland 20707 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of H rtificate of I			giene Reg. No.	2000	10000
	Ø.		Decedent's Name (First, Middle, Last	st)				2. Date of De	ath	<u> </u>	3. Time of Death
	Physicia /Medic		Alfred Linwood De					April		08 Year	11:30aMn
	Examin	er	4a. Facility Name (If not institution, give				Location of Death			County of Death	
			Crescent Cities 1  5. Social Security Number 6. S			Riverda If Under 1 Year	LE If Under 24 Hrs.	8. Date of Bir	th	ince Ge	
'n	Funeral Director			2 F 81	Yrs.	Months Days	Hours Min.	02/22/	iy, Year)	Virg	pplace (State or Foreign Intry) ginia
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	cation					10d. Inside City Limits
	shov shov	'n	DC 100. County		shingt						Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip Code		Ţ	10a. Citiz	en of What Cou	untry?
	aa or		1136 44th Place,	SE		20019	)		Uni	ted Sta	ates
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. \	Was Decedent of H		pecify Yes or No		4. Race - Amer	ican Indian,
336	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other tran "natural", or Items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 <b>7⊑</b> Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2511No	Specify:	o Rican, etc.)	1	Black, White Specify: B1a	·
15-0036	iin 72 hoi n "natur Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kin	d of Business/I	ndustry
2121	d with giene ar tha the l	mo;	12th	College (1°401 5+)	Logi	stics Spe	ecialist		Fed	leral G	overnment
g	al Hy d othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		, Maiden S	Surname)	
Maryland	Ment Ment Marked Marked	ဥ	William Dougans  19a. Informant's Name/Relationship (		100 11-11	ng Address (Street	Mary Ha		0.4	T 01-1- 7	"- O- 1-1
Z	nd 2 shalth and 27 is n		Agatha Dougans	Wife		44th P1.				20019	ip code)
Ze,	es 1 a of Hez fitem		20a. Method of Disposition		lace of Dispo emetery, crer	sition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or	Γown, State
Ē	Pages ment of ant: If its ury or o		Was Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			et Cemete	3	9/2008	Was	shington	n, DC
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service Lice	mull		Name and Addre	30				al Home, LLC 20017
ľ.	B 1		232. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.							Approximate Interval Between
O	Physician		immediate Cause (Final disease or condition	a. Acute Myoca							Onset and Death  1 minute
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						_
		er	Sequentially list conditions, if any, leading to immediate	b. Urinary Tra Due to (or as a consequence)		ection					1 Day
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	^							
Ö,	e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
68760,	ficate be executed physician and s the burial-transit	edical		d							
_		/Me	IF FEMALE:	23c. If yes, outcome pf pregna	incy				2	3d. Date of deli	ven
Вох	death atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	4			Month	Day Year
O.	at the de by the a	hys	9 □ Unknown	9LlUnknown			<del></del> -				
Vital Records, F	as the	þ	Part II. Other significant conditions of Dementia	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.			se contribute to ] No 3  □ Pr	the cause of death? obably 4 13 Unknown
Ö	aw require s been siç s should b	Completed						24a. Was		24b. Were au	topsy findings available
Ä	The lav	om						auto perf 1 Yes	ormed?	death?	completion of cause of 2 NO
Ita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
<u>~</u>	hysic this ce	To [	1 ☐ Yes 21 No		ER/Outpatier		4 W Nursing H	lome 5 Res			cify)
Division or	ling P	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ryat fk? Yes 2∐No	28d. Describe	how injury	occurred	
<u> </u>	death death ctor:	licat	2 Accident investigation 3 Suicide 6 Could not be determined		ome, farm, str		163 2 140	28f. Location	(Street and	l Number or Ru	ıral Route Number,
2	al or A s after al Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)			City or To	iwn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical (		nysician: To the best of my kno niner: On the basis of examina and manner stated.							
	within To th	Me	29b. Signature and title of Artifier			29c. Licens			^	signed (Monti	
)	111	1	> Helle I Dry	MIR		D259	914		Hr	PUL 4,2	008
	()/		30. Name and address of person who	•							
	JYC.		PLLEN BRIMPER	M. D. 4409 32. Registrar's Six pe	East-W	est High	way, Rive	erdale,	MD	-	
	Sta Registr		31. Date filed (Month, 2008 ear)	Server As a server							

			1 - For State Registrar		State of M	laryland		artment of			Mental Hy	/giene Reg. No	21111R	12831	1
			Decedent's Name (Fig. 1)	rst, Middle, La	ıst)						2. Date of D	eath		3. Time of Death	_
н	Physici		Carol	Ann	Des	borous	zh				Month March	28 -	•	2:15 p M	4
	/Medic Examir		4a. Facility Name (If not				···	4b. City, Town	, or Loca	ation of Death			. County of Death	2.13	
			15610 Mar.	athon	Circle			Gai	hers	sburg		M	ontgomer	V	
	Funeral		5. Social Security Numb			ge (In yrs. las	st birthday)	If Under 1 Ye Months Dar	ar If U		8. Date of B	rth	9. Birth	place (State or Foreign	n
	Director		222-30-366	/	1 □ M 2 💢 F	64	Yrs.	WORKING Du				-	1944 Cal		
	pue *		Usual Residence of Dec	edent c. County		10c City	Town or Lo	ncation						10d. Inside City Limits	_
	lanyta   •ho	ō		,										1 ☐ Yes \$ TVNo	
	h the Maryland r 28a-f ehow	Director	Maryland Me 10e. Street and Number	ontgom	ery	Gaith	ersbu	1rg 10f. Zip Cod				100 Ci	tizen of What Cou		_
	hours after death with the Maryland tural, or Items 23e or 28e-f ehow al Examiner must be notified at			than C	i1- # 20									,	
	ne 23	Funeral	15610 Mara	LHOH C.	12. Was Decedent		13.	20878 Was Decedent	of Hispan	ic Origin? (Sc	ecify Yes or N		ted State		_
^	fler d	F	1 Never Married	2 ☐ Married	Armed Forces 1 ☐ Yes 2 🔯	?	10.	f Yes, specify C	uban, Me	exican, Puerto	Rican, etc.)		Black, White,		
3	urs a	by	3 ☐ Widowed 4 🔀		If Yes, Give Year or Dates:			1 ☐ Yes 2 🛱 1	lo Sp	ecity:			Specify: Wh:	ite	
Ş	be filed within 72 hours after death with ital Hygione. Id other than "natural", or Items 23s or event, the Madical Examiner must be.	Completed		Decedent's E			16a. Dece	dent's Usual Oc	cupation			16b. K	(ind of Business/Ir	dustry	_
215-0036	within 72 ene. then "na!	ple	Elementary/Secondar		ade completed) College (1-4or	5+)	life.	kind of work do DO NOT use re	ne during ired)	most of wor	ang				
N	e filed within al Hygiene. I other then "	Хоп			4		Mana	ıger					relecomm:	unications	
and	al Hy d oth	Be (	17. Father's Name (First	, Middle, Las	7)			J	18.	Mother's Nam	e (First, Middle	e, Maider	Sumame)		
5	should be nd Mental marked o umatic eve	7	Thomas Rog	gers					No	rma Bu	rge				
Mar	es 1 and 2 should to of Health and Ment I tem 27 is marked r other traumatic		19a. informant's Name/										or Town, State, Zij	Code)	
_	and ealth m 27		Davin Desbo		-Son			rgreen		, Amhe	rst, NI	1 030	031		
ore	of H of H or off		20a. Method of Dispositi		Removal from State	con	ce of Dispo netery, crer	sition (Name of natory or other)	olace)	4-4-	Date -2008		ocation - City or T		
aitimor	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐				opoli	tan Cre	mato			Alex	kandria,	Virginia	
ğ	permit. Pages Department of I Important: If Its eny injury or o		21. Signature of Funera	Service Lice	nsee		22	. Name and Ad	dress of l	Facility Si	mple Ti	ibut	te		
_	205 g			9									Le, MD 20	852	
			23a. Part1. Enter the di shock, or heart fail	sease or con ure List only	nplications that cause one cause on each l	d the death. line.	Do not ent	er the mode of o	tying, suc	ch as cardiac	or respiratory	arrest,		Approximate interval Between	
1	Physician		Immediate Cause Fina disease or condition	100	a. Metast		roogt	Canaan					5	Onset and Death Years	
	/Medical Examiner		resulting in death)	•	Due to (or as	s a conseque	nce of):	- <del>cancer</del>							_
	LAditiilei		Sequentially list condition	ns,	b										
-	sit ad	Examiner	cause. Enter Underlying Cause (Disease or injury	late 2	Dua to (or as	s a conseque	nda oi).								
	and and I-tran	каш	that initiated events resulting in death) Last		C. Due to /or or	s a conseque	nno of):								_
2/00,	cien cien buria	E I	,		Due to (or as	a conseque	RCB OI).								
0	cate be executed physicien and the burial-transit	dical			d										¥
X	it the death certificate be executed by the attending physicien and tached for use as the burial-transit		IF FEMALE:		23c. If yes, outcome	a of oregonous									
0	atten for u	Ician/Me	in the past 12 mon 1 ☐ Yes 2 ☑ No		1 ☐ Live birth	2 🗋 Fetal d	eath 3	Ectopic pregnal Other (specify)					23d. Date of deliv Month	ery Day Year	
5	he d	Physic	1 ∐ Yes 24∑ No 9 ☐ Unknown		9☐ Unknown	it time or dea	ai 5_	Jotner (specify)							
ŗ.	requires that the death een signed by the atter nould be detached for u	F.	Part II. Other significant	conditions	contributing to death I	but not resulti	ing in the u	nderlying cause	given in	Part I.	23e. Did	tobacco	use contribute to t	he cause of death?	_
	w requires that s been signed b should be dete	d by					-	. •			10	Yes 2	√ No 3 Proi	pably 4 □Unknown	1
cords		Completed							-				7		_
ยั เ	The law ate has b page 2 sl	d m									24a. Was	OSV	prior to co	opsy findings available impletion of cause of	3
			06 11/1-1-1-1									ormed?	1 ☐ Yes	2□ No	
=	ysicion: The law is certificate has b director, page 2 s	o Be	25. Was case referred to examiner?	medical	Hospital:						h Check only	177			_
อี		$\vdash_{\parallel}$	1 ☐ Yes 2 ☐ No 27. Magner of Death		1 ☐ Inpati		VOutpatien  8b. Time of	JUDOA	41	☐ Nursing Ho	28d. Describe		6 Other (Special	(y)	_
5	ding th. Afte	盲	X	Pending investigation	(Month, Da	ay Year)	Injury		ijury at vork? □ Yes	2 🗆 No		morr ingo	.,		
<u> </u>	Atter dea octor y the	flca	3 Suicide 6	Could not b	e One Place of In	jury - At hom	e, farm, str				28f. Location	Street ar	nd Number or Run	al Route Number.	_
5	after after din the	Certification:	4 🗌 Homicide	dotominod	building, e	tc. (Specify)		,			City or To	wn, State	9)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funersi Director: After this certifica completely filled in by the funeral director.		29a. Certifier	Certifying Pl	nysician: To the best	of my knowle	edge, death	occurred at the	time, da	ite and place,	and due to the	cause(s	) and manner as s	itated.	_
	ne Hc	Medical	(Check only 2 1	Medical Exa	miner: On the basis of and manner st	of examination	n and/or inv	estigation, in m	y opinion	, death occur	red at the time	date an	d place, and due t	o the cause(s)	
	To the Comp	ž	29b. Signature and title	of certifier	$\gamma$	6		29c. Lice	nse nurr	nber		29d. Da	te signed (Month,	Day, Year)	_
•	10		Treat	10-1	lan (	in	OMA		00	531	37	AO	(11 02	, 2008	
	4		30. ame and address of	f person who	completed cause of	death (Item 2	За) (Туре,	Print) Lei:	sha i	A. Emen	s, M.D.	1			
			401 NORT	TH B	ROADWA	14	BA	LTIM	ORF	= 1	1ALVL	AN	0 212	231-2410	5
	Sta		31. Date filed (Month, Da			rar's Signatur	8	DE D							
	Registr	:[1	APR	0 4 20	08	cas Afo									

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04/02/2008<sup>ea</sup> 1:00 a M Margaret Louise DeMarco 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert Chesapeake Beach 3552 Karen Drive If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 03727/1919 Washington, DC 1 □ M 2 T F 579-01-7096 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Chesapeake Beach Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20732 3552 Karen Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Branson Aubrey Hardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3550 Karen Drive, Chesapeake Beach, MD 20732 Michelle Ranere/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cem 04/17/2008 Arlington, VA 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signatur of Funeral Service Licensee 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Month Day

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

þ

Completed

Be

ျ

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or iten

event, the Medical

Baltimore, Maryland 21215-0036

Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit new. by Physician/Medical

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? Yes 2500 1∏ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes ZENo 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

XRW) State

within 24 hours a To the Funeral I

Medical

29a. Certifier

29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MD 20678

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Jonathan Lowenthal, MD Calvert Internal Medicine 110 Hospital Road Prince Frederick

32. Registra Signature APR 31. Date filed (Month, Day, 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Richard Edward Deering 2008 March 17:33 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital of Cecil County E1kton Ceci1 if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 XM 2 ☐ F 192-20-3825 82 March 11,1926 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Ceci1 North East 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 First Street United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinist Foreman Ironworks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Deering Florence Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 Mary Deering / Spouse P.O. Box 693,32 First Street, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Mayerdale Crematory 4 Donation 5 Other (Specify) 5, 2008 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Fuperal Service Licensee 127 South Main Street, North East, Maryland21901 Approximate
Interval Between
Onset and Death
UNKNUM 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Myocardia Due to (or as a consequent Atherosclerosis DEONALY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of).

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

٩

**Funeral** 

Director

show

Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked or

permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other tonce.

or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-transit attending physician the detached

by Physician/Medical Examiner

Be Completed

Certification: To

Medical

been signed by should be detac certificate has page 2 s ours after death.

Jeral Director: After this certific filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last	CDue to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
		4a. Was an autopsy performed?  ☐ Yes 2 No   24b. Were autopsy findings available prior to completion of cause of death?  ☐ Yes 2 No   1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At nome, farm, street, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, ty or Town, State)
	integral to the best of my knowledge, death occurred at the time, date and place, and du	

29c. License number

10002832

29d. Date signed (Month, Day, Year)

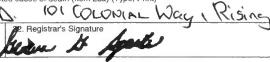
To the Hospital within 24 hours a To the Funeral I

> State Registrar

31. Date filed (Month, Day, 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



ORIGINAL

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Maryland / Department / Departm	Mental Hygi	ene	128	37
	Dhunini		Decedent's Name (First, Middle, Last)	2. Date of Death Month	h Day Year	3. Time of D	
	Physicia Medic/		Arthur Richard ECHBONIE	April 8	3 2008	5:30	РМ
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Deat		
			Julia Manor     Nursing     Home     Hagerstown       5. Social Security Number     6. Sex     7. Age (In yrs. last birthday)     If Under 1 Year     If Under 24 Hrs.	8. Date of Birth	Washin	gton thplace (State or	Foreign
	Funeral Director		1 M 2 F Vrs Months Days Hours Min.	Month, Day,	Year) Co	yland	, oroigir
			220-69-2468 86 Usual Residence of Decedent	Whiri 2	1922   Hai	ylanu	
	nylan how	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City	
	e Ma Sa-f s	cto	Maryland Washington Hagerstown	··-		<b>™</b> Yes	2 [] NO
	or 24	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	ountry?	
	s 23e		33 Elizabeth Street 21740  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	agaifu Vag as Na	USA 14. Race - Ame	encan Indian	
	item Item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Never Married 2 ☐ Married  1 ☐ Yes, Specify Cuban, Mexican, Puerton 1 ☐ Yes, Specify Cuban	o Rican, etc.)	Black, Whit		
980	urs af	þ	If ∀es, Give 1 ☐ Yes 2 ₹ No Specify: Year or Dates:		Specify: V	Vhite	
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work		16b. Kind of Business	/Industry	
2	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	naig .			
2	led w lygier her th	S	8 0 None	ne (First, Middle, N	Non	e	
and	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Modical Examinational be multified at	Be					
Ž	d Mel d Mel mark matic	ဥ	Jack Ezzechielle Iacobone Laura  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	Irene El		Zin Code)	
Maryland	nd 2 s Ith an 27 Is trau				y1and 2178		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiliation ust be indiffied at once.		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	-	20c. Location - City or		
altimore,	Page: ent o nt: If ry or		1 \( \text{Burial} \) 2 \( \text{Cremation} \) 3 \( \text{Removal from State} \) 4 \( \text{Donation} \) 5 \( \text{Other} \( \text{Specify} \) Rose \( \text{Hill Cemetery} \) 4/11	/08 1	Hagerstown	Morv1s	and
ati	mit. partm corta finju		Robe Hill demetel, 14711	Account to the second s	Funeral Ho	, , , , , , , , , , , , , , , , , , , ,	ind
m	Depar Impo		Cottle // January 415 E. Wilson Blvd				740
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)  a.   The partial partial process is a consequence of the conse			Onset and D	eath
Н	/Medical Examiner						
	LXamille	_	Sequentially list conditions, b. Cue to (or as a consequence of)				
	led nsit	Examiner		Lun T	) 15eass		
	al-trai	xar	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and pace 2 should be detached for use as the burial-transit	cai	d.				
ø	tificat ig phy as th	Physician/Medicai			1		
Вох	es that the death certific igned by the attending p be detached for use as	an/N	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	,	
E	e deal he att	sicia	in the past 12 months?  1  Yes 2  No  9  Unknown		Month	Day Y	ear
0	at the	Phy	9 Unknown	One Didash	pacco use contribute to	a the sause of de	
	signe d be d	by	the district of a significant contributing to death but not resoluting in the distributing cause given in a art.			robably 4 U	
oro	w requir been si should	Completed	Demont	-			
Jec	e law	mpi	Depression	24a. Was ar autops perform	y prior to	utopsy findings a completion of ca	vailable iuse of
Division of Vital Records,	ifcian: The lar certificate has rector, page 2			1 ☐ Yes 2	2. ■No 1 ☐ Yes	2 □ No	
Ξ	Attending Physician: ir death. ector: After this certifici by the funeral director.	o Be	examiner?	ith (Check only on	e) ence 6 □Other <i>(Spe</i>		
o	Phys or this oral di	To tr	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		w injury occurred	нспу)	-
<u>o</u>	nding F ath. r: After e funer	ation	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
<u>Vis</u>	or Attendi after death Director: A in by the fi	tifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or R. L. State)	ural Route Numb	er,
	tal or A	Certification;	Culturing, Stor. (Specify)		,		
	To the Hospital or Attending Physician: The Sahin 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, and the basis of examiner				
	To the To the sompl	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mont		
1	XX		June mules	96	04/09/	0 4	
L	3			pal	court		
			FARIO MUNICILES	ws m	0-2174	10	
	Sta Registr		31. Date filed (Month, Par Year) 9 2008 32. Reastrar's Signature				

			State of Maryland / Dep	ertment of Hea				200	8 12838
	•		- negisuai	ertilicate of De	alli	2. Date of Dea	Reg. No.	in fine fine	3. Time of Death
*	Physicia	an	1. Decedent's Name (First, Middle, Last)			Month MRIL	Day	Year	(0, 27
	/Medic		ERCEL J. EMSWILER	T		MKIL	08	200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc				ounty of De	
			GOOD SAMARITAN HOSPITAL		MSAE Under 24 Hrs.	8. Date of Birt		ltimo	
н	Funeral		5. Social Security Number 6. Sex 1		lours Min.	(Month, Day	y, Year)		irthplace (State or Foreign Country)
-	Director		217-16-2513 S5 Yrs. Usual Residence of Decedent			March :	11 19	23 M	aryland
	and w		10a. State 10b. County 10c. City, Town or L	ocation					10d. Inside City Limits
	Aaryl f sho ed a	ō	M 1. 1 P.14.						1 ☐Yes 2X No
	the 7	Director	Maryland Baltimore Baltimo:	10f. Zip Code			10g. Citize	en of What (	Country?
	with a or				,		TTC	A	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	3313 Woodside Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13	21234 . Was Decedent of Hispa		cify Yes or No-	US - 14		nerican Indian,
	ter d iten iner	F	1 Never Married 2 Married 1 Yes 2 N No	. Was Decedent of Hispa If Yes, specify Cuban, N		Rićan, etc.)		Black, Wh	nite, etc.
39	ırs al	by	3 ¼ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Si	pecify:		5	Specify:	White
ŏ	2 hou	ed		edent's Usual Occupation		1	16b. Kind	d of Busines	ss/Industry
712	in 7: In "n Medi	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during DO NOT use retired)	ng most of workin	ng			
212	d with giene r tha	Completed		t Metal Work	ker		Airc	raft l	Manufacturer
g	should be filed within 72 hours after death with the Marylan ad Mental Hygiens and Mental Hygiens marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18.	. Mother's Name	(First, Middle,	Maiden S	urname)	
a	ald be fenta rked tic ev	To E	James Franklin Knight		Lottie	Mae Mye	ers		
Maryland 21215-0036		-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and	Number or Rura	l Route Numbe	er, City or	Town, State	, Zip Code)
Š	nd 2 ulth a 27 lt		Marlene Barger - Daughter 123	Grand Oak I	Orive, H	agerst	own,	Md. 2	1740
<u>6</u>	一十 か を		20a. Method of Disposition 20b. Place of Disposition	oosition (Name of ematory or other place)		ate			or Town, State
Ē			1 Burial 2 Micremation 3 Hemoval from State	own Cremato	ry 4/10.	/08	Hage:	rstowr	n, Maryland
altimore,	permit. Pag Department Important: I any injury o once.			22. Name and Address of		nnich l			
ñ	permit. Departr Importa any inju		Jest Munney	415 E. Wilso					
F			23a. Part. Enter the disease, or complications that caused the death. Do not enabled, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final						Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	CARDIAL .	INFAR.	CTION			
В	Examiner		CONCESTIVE	HEART	FAILE	35			
Š.	eu -	ē	Sequentially list conditions.	II Erlie)	1 -1 / 1/				3
	uted J ansit	i i	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	126315					
<u>,</u>	be executed sician and burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	d						
89	ificate g physi as the b	edi							
ŏ	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23	3d. Date of o	delivery
P.O. Box	death atte	icia	in the past 12 months?  1	☐Ectopic pregnancy ☐ Other (specify)				Month	Day Year
O.	the oy the	nys	9 ☐ Unknown						
	w requires that the debeen signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given ir	n Part I.	23e. Did to	obacco us	e contribute	to the cause of death?
8	quire; n sig ald bi	d b	HYPERTENSION ATRIAL FIBA	216ATION,		1 🗆 '	Yes 2□	]No 3□	Probably 4-Unknown
Vital Records,	w rec	Completed	DYSCIDIDEMIA	·		24a. Was		24b. Were	autopsy findings available to completion of cause of
æ	he la e has age 2	щ	013611111111111				ormed?	death	?
ā	sician: The law certificate has b irector, page 2 s		25. Was case referred to medical	26	6. Place of Death	1 Yes	2 No	1 □ Y	es 2 No
>	s cert	o Be	examiner?  1 Yes 2 No Hospital: Impatient 2 ER/Outpatient	Othor	4 ☐ Nursing Hor			MOther (S	paciful.
Division or	Phy er this eral c	: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		28d. Describe I			респу
o	ding h. : Afte	tion	1⊿ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		2 □ No				
<u> S</u>	Atter deal	Certification:	3 Suicide 6 Could not be 28e, Place of injury - At home, farm, s	street, factory, office	2	28f. Location (	Street and	Number or	Rural Route Number,
á	after after Dire	erti	4 Homicide determined building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de-						
	le Ho	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opini-	ion, death occurr	ed at the time,	date and	place, and o	tue to the cause(s)
	To th Vithir To th	Me	29b. Signature and title of certifier	29c. License nu					onth, Day, Year)
	15		h. Lis M.D.	RES	-000		AP	RIL (	08, 2008
	X'/~		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)					MO, 21239
	5		Mister Hai Charl Inc.	RIVEN	BLUD	BA	LTI	NORE	MO, 21239
	Sta	te	21 Date filed (Month Day Year) 32 enistrar's Signature	books			, ,		
Ĝ	Registr		APR 0 9 2008						

Amend Item 9 State of Maryland / Department of Health and Mental Hygiene 2 UUS 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ewel Year **Physician** 936 M 2008 larvin inwood /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Medical Center Vicimica enusula alisburo 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Months 1 M 2 □ F Days Min Mari Director MD Usual Residence of Decedent 10b. County 10a. State 109-City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director  $\mathcal{UD}$ Comico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must b Scola 9180 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2☑No Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be l and 2 should be fi lealth and Mental H ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10725 Evenin permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other treas ster 10725 Evening laine Wind 21044 lumb19 MO Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Grastill md 4 □ Dorration ि ☐ Other (Specify) 2008 Um Signature of Fun-Val Service Licensee 22. Name and Address of Facility Bennie South Funeral Home Salis bury 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition week **Physician** preumana resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an atria has autopsy performed certificate 1∐ Yes 2 No Vital Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this ō completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charle B. Silvia Jr My Peninsula Regional Medical (Enter Salisbury mas) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 12840

		1- For State Registrar	Certif	icate of Dea	th .	Reg.	No.	10.00 A
Physicia	in/	Decedent's Name (First, Middle,Last				Date of Death     Month     D	ay Year	3. Time of Death 0105 hrs
edical Exami	ner		ugeria 2/2	ey -	He.	April 2, 2008	3	01051115
		4a. Facility Name (if not institution, give Waller Road	street and number)	4b. City	Town, or Location of Death	1	4c. County of Death Wicomico	
Funeral		Social Security Number 6. Se	x 7. Age (In yrs. last		der 1 Year If Under 24Hrs	s. 8. Date of Birth(	MM/DD/YYYY) 9. Birt	hplace (State or
Director		29-18-1612 12		A Yrs. Mor		_ ,	/ Foreig	n untry) MD
	ľ	Usual Residence of Decedent				- /	7	10d. Inside City Limits
ow any		10a. State 10b. County		wn or Location				1 Yes 2 No
yland 1-f she	흱	10e. Street and Number	nico X	115/201	ip Code	10g	Citizen of What Cour	ntry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	1023 5. 11	1-200 DO		21801		1 le SA	
with the ms 23a be noti		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? ( S cify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
r death wi	Funeral	1 Never Married 2 Married	1 Yes 2 No		2 No specify:	or troom, otory	Specify: R	lack
hours after 'natural'', Examiner	à	Widowed 4 Divorced     Decedent's Education (Specify on	or Dates:	Sa. Decedent's Usu	al Occupation (Give kind of	work done 1	6b. Kind of Business/I	ndustry
72 hou n "nat al Exa	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of v	orking life. DO NOT use re	tired)	1 /10 6	2
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	ompleted	1018			None	a (Ciast Middle Ma	Mar Sumama)	
21215-003 uld be filed withi Mental Hygiene, marked other tt	ပ္ခု	17. Father's Name (First, Middle, Last)	01	Qua	Delor.	e (First, Middle, Ma	Johnson	$\overline{}$
md 2 should be filealth and Mental I tem 27 is marked traumatic event,	To B	19a. Informant's Name/Relations p (T	ype, Print )	19b. Mailing Addre	ss (Street and Number or		er, City or Town, State	, Zip Code)
e, MD 1 and 2 short Health and item 27 is retraumation		Delores Johns						0
ore, Mes 1 and 2 of Health If item 2		20a. Method of Disposition  1 Burial 2 Cremation 3		ce of Disposition (Natory or other plan		Date	20c. Location - City or	rown, State
Page Page ant;		4 Donation 5 Other Specify:		wer Hill	141	5/2008	tden	mn
Baltimo permit. Pag Department Important; injury or ot	1	21. Signature of Funeral Service Licen	see L	A	nd Address of Facility	111	917 Isabe Salishwa	Ma ST 21861
Physician	1	23al Part I. Enter the disease, or comp		o not enter the mod	e of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical kaminer		failure. List only one cause on ear Immediate Cause (Final disease a.	Multiple Injuries					Death
\ammici		or condition resulting in death)	Due to (or as a consequence of):					
	er		Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
ecuted and - transit		d.						
ial ial	/Medical	UNPENDED	AMENDED					
3760, ificate be ig physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnal  Live birth	ncy 2 Fetal dea	th 3 Ectopic pregi	nancy	23d. Date of deliver Month	y Day Year
Box 68' death certification attending and for use as	sician	past 12 months?  1 Yes 2 No 9 Unknowr	4 Pregnant at time of death					
O. Bc t the dea by the a	Phys	Part II. Other significant conditions	9 Olikilowii	ulting in the underly	ing cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?
, P.O ires that t signed by	ð	, ar iii ouloi olgiiiilouli ooliulisii	continuous to document to	,	J	1 Yes	2 🗸 No 3 Pro	bably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed					24a. Was ar		utopsy findings available completion of cause of
e law te has ge 2 sl	dmo	·				perform	ned? death?	
tal Rec cian: The certificate ector, page		25. Was case referred to medical			26.Place of Death (Chec	k only one)		
of Vital ng Physician: After this certi nneral director	To Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatient 3	DOA Other Nurs		Residence 6 🗸 Othe	er: Scene
n of ding Pl After funeral		27. Manner of Death  1 Natural 5 Pending	(Month Day Year)	8b. Time of Injury	28c. Injury at Work?  1 Yes 2 ✓ No		ow injury occurred xed object collisi	on
Division tal or Attendi rs after death. al Director: /	cati	2 Accident Investigati	on 28e Place of Injury - At hom	ne. farm. street. fact		28f. Location (St	reet and Number or R	ural Route Number, City
Divis pital or At ours after d cral Direc	Certification:	3 Suicide 6 Could not determine	be	,,,	,	or Town, Sta Waller Road, D	ate)	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. The Funeral Insector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge r:On the basis of examination and	, death occurred at	the time, date and place, a	nd due to the cause	e(s) and manner as sta	ted.
To th withis To th	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number	, 44.5	29d. Date signed (M	
	_	Down me Dine	Limm.		O.C.M.E.		April 2, 2008	
		30. Name and address of person who	completed cause of death (Item 2					
			Assistant Medical Exami		n Street, Baltimore,	MD 21201		
S Regis	tate trar	31. Date filed (MoAPR, Yoar) 2	008 32. Sistrar's Signatur	* Aproved				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 12:40 A M April Patricia Mae Firey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Spring 14702 Fairview Church Rd Clear Washington County 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, Year)
Nov 7,1940 Funeral 1 □ M 2 Ϊ F Months Days Hours 67 Nov Director 219-38-5361 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Clear Spring Maryland Washington County Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14702 Fairview Church Rd Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Registered Nurse Health Department 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Carlton Parsley. Sr. Mildred R. Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Thomas E. Firey-husband 14702 Fairview Church Rd Clear Spring, MD 21722 20b. Place of Disposition (Name of cematery, crematory or other place)
Mt. Tabor Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4-8-2008 Fairview. Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Fastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, are complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Présidence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Man E Mono Hazerstown, MD 21740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WD 35 4 Wil · Money 16H-12 32. Registrar's Signature State APR 09 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 31<u>,</u> 4:35 P<sup>M</sup> Pauline Folkers 2008 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Montgomery Kensington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🔀 F 528-38-4824 83 Oct. 12, 1924 Canada Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Marvland Montgomery Garrett Park 10e. Street and Number 10g. Citizen of What Country? 11300 Kenilworth Avenue P.O. Box 132 20896 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify þ Specify. 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Schafer Mary Roh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20896 Richard A. Folkers / Son 11300 Kenilworth Ave. Box 132, Garrett Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 4/4/2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e Final disease or con mon resulting in death) Congestive Cardiomyopathy Due to (or as a consequence of): Ischemic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offs Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Living 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner be executed burial-tran and レルトによる Division or Vital Records, P.O. Box 68760, physician the for use the a signed by t page 2 certificate Hospital or Attending Physician: 24 hours after death. After

Examine Physician/Medical ģ Completed Be 2 Certification:

Medical

State

Registrar

**Physician** 

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

n and Mental Hygiene. filed within Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

**Physician** 

/Medical

death with the

72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Be

27. Manner of Death 1 🖾 Natural 2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated

M.D.

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

1 🕱 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

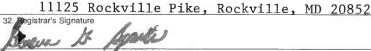
D27660

April 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Gaswami, **MDPA** 31. Date filed (Month, Day, Year)

04 APR 2008



DHMH 17 Rev 1/2001

24 hours after death Funeral Director:

To the I within 24

Sequentially list conditions, process of light of the conditions and the past 12 mg/ms <sup>2</sup> and th		1	For State Registrar		State of M	arylar		artmen rtificate			and M		Rag. No	0.5	0.8		284
As Facility Name (if not related, specified and number)  As Facility Name (if not related and number)  Home steed And nor  Social Security Number (if not related and number)  2.66-12-2478  2.66-12-2	Physician			-								Month	Da	y acce	ear		
Home stead Manor  5. Sicila Search Number  5.	/Medical	ŀ						45 03	T	1 1	/ D - + 1	April			Dooth	11:2	0 A M
## Section   Control   Con	Examiner			ve str	eet and number)					Location	or Death		40				
2.46—1.2—4.378	- Francis			Sex	7. Ao	e (In vrs.	last birthday)			If Under	24 Hrs.	8. Date of Bir	th	9	Birtho	ace (State	a or Foreig
The state of the								Months	Days	Hours	Min.	(Month. Da	v. Year	)	Coun	try)	
Social State   100   1																	
Special Part   State	Mo ∰		10a. State 10b. County			10c. Ci	ty, Town or Lo	cation							1		
A	ga-fa	3 1		er			Cambr	idge									JS Z A IN
Marial 2   Command   3   Removal from State   Mary Land   4   Donatory   5   Coltes (Specify)   5   Coltes (Spec	or 28							10f. Zip					10g. Ci			try?	
A Brain   2 December   5 Other (Sepect)   21. Signature street the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate should be shoul	1238 Mart	5															
MD Veterans Cemetery 4/10/2008   Beulah, Maryland	tems income			12	Armed Forces?		.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	)-				
WB burst   2   Cremation   3   Femoval from State   MD Veterans Cemetery   4/10/2008   Beulah, Maryland   24   Donatory   5   Chem's Repectory   21   Singlayor of Auroral Survice Luffers   22   Singlayor of Auroral Survice Luffers   23   Singlayor of Auroral Survice Luffers   24   Singlayor of Auroral Survice Luffers   25   Singlayor of Auroral Survive Luffers   25   Si	, a				If Yes, Give	No		1 □ Yes 2	2X No	Specify:				Specify:	V	hite	
WB burst   2   Cremation   3   Femoval Floor   MD   Veterans Cemetery   4/10/2008   Beulah, Maryland	a Ex	2   2		Educa			162 Dece	dont's Heur	I Occupa	ation			16b k	Cind of Busin			
A Donatory College (September 2) College (	na lete		(Specify only highest g		completed)		(Give	kind of wor	k done c	luring mos	t of work	ing	100. 1	Cirila or Busin	1022411	lustry	
MD Veterans Cemetery 4/10/2008   Beulah, Maryland	than than				College (1-4or	5+)				,			0	wn Ho	me		
A Donainty   Commerce   Commerc	Hygin the C			<i>t)</i>			Homom			18. Mothe	er's Name	e (First, Middle					
MD Veterans Cemetery 4/10/2008   Beulah, Maryland	sed o	í								Dai	CV (	Maiden	Sur	name	Unkr	orm)	
A Brain   2 December   5 Other (Sepect)   21. Signature street the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate should be shoul	mari mati			Турв	. Print)		19b. Mailir	na Address	(Street a								
WB burst   2   Cremation   3   Femoval from State   MD Veterans Cemetery   4/10/2008   Beulah, Maryland   24   Donatory   5   Chem's Repectory   21   Singlayor of Auroral Survice Luffers   22   Singlayor of Auroral Survice Luffers   23   Singlayor of Auroral Survice Luffers   24   Singlayor of Auroral Survice Luffers   25   Singlayor of Auroral Survive Luffers   25   Si	th ar	if						-									
WB burst   2   Cremation   3   Femoval Floor   MD   Veterans Cemetery   4/10/2008   Beulah, Maryland	Heal ther	J:		6		20b. F							_			wn, State	
Approximate interval Enter the disease, or odmolication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Introduct between close or each line.    Immediate Cause (Final disease or conditions, and the cause of line)   Due to (or as a consequence of):	nt of t: If is				noval from State	1					/10/	/2008	Pou	lab '	Maxi	-1 and	
Approximate interval above and of the cause of contributing to death of the cause of contributing to death of the cause of the cause of the contributing to death of the cause of the caus	njury njury	-			10,0	1										/Land	
The past is more in the pa	Dep Impo		JANIAN I		500	01	Ž	ëllër Ob Ma	Fun	eral	Home	P. O	. Bo	x 207	MT) 1	11631	
Insert and Death Medical xaminer  To great a consequence of the condition of a consequence of the consequenc		(	3 Port1. Enter the disease, or co	nolica	tion that causes	the deat								noo, .	-		
IFFEMALE:   23d. Date of delivery   23d. Date of del	/Medical examiner		resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	b.	Due to (or as	a consec	uence of):	76	* Y								
See and   See	the attending physician in the for use as the burial visician/Medical Exercise.	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d 230	. If yes, outcome 1 □ Live birth 4 □ Pregnant a	of pregna	ancy									-	Year
See a composition of the control o	an signed by uld be detac	2	Part II. Other significant conditions	contri	buting to death b	eut not res	ulting in the u	nderlying c	ause give	en in Part I.							
25. Was case referred to medical examiner?    1   Yes   2   No	te has be age 2 sho omplet									<u> </u>		auto: perfo	psy ormed?_	prid dea	or to con ath?	npletion of	is availab cause of
29b. Signature and title of certifier  29c. Clear of person who completed cause of death (Item 23a) (Type, Print)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	و يوان			T-						26. Place	of Deat						1
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	s cer direc	3		Hos	spital:	ent 2	ER/Outpatier	nt 3 DO	A Othe					9 Wither	(Specify	Priss	130
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ath. r: After thi e funeral		1 ■Natural 5 □ Pending	on	28a. Date of Inju (Month, Da	iry y Year)				at							
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)	rs after de al Directo ed in by th		determine		28e. Place of In building, el	ury - At h c. <i>(Speci</i> i	ome, farm, str	eet, factory	, office						or Rura	l Route Nu	ımber,
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	n 24 hound ne Funer Metely fill edical	3	(Check only 2 Medical Ex		r: On the basis of	f examina											∌(s)
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Withit Comp		29b. Signature and title of certifier										29d. Da	ate signed (i	Month,	Day, Year,	)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				_			MD	2	>0	353	2 5	55	4	171	120	800	
Melinde Butter 136 Lednum Arre Preston MD 21655	)		30. Name and address of person wh	o com	pleted cause of o	leath (Iter	n 23a) (Type.	Print)						•			
	State		31. Date filed (Month, Day, Year)	9 2	32. Reg (t	ar's Signa	ature	4									

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H tificate of L			ene	8	12844		
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Dav	Year	3. Time of Death		
	Physicia		Robert Lee Fooks					April		8008	15:30 PM		
	/Medic Examin		4a. Facility Name (If not institution, giv	street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death			
		٠.	Atlantic General	Hospital		Berlin			Wo	rcest	ter		
	Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthpl	lace (State or Foreign try)		
	Director		214–30–8114	₩ 2 □ F   7	4 Yrs.	Months Days	Hours Will.	Jan 18,	1934	MI	<u> </u>		
	p.		Usuel Residence of Decedent		100 City Town and					1/	Od. Inside City Limits		
	aryla shov	-	10a. State 10b. County DE Sussex		10c. City, Town or Lo Seaford	cation				"	1 XYes 2 □ No		
	8a-f	cto			Searord								
	or 2	Director	10e. Street end Number			10f. Zip Code		10	og. Citizen of V		try?		
	ath v 238		804 3rd St.			19973			USA		an India		
	er de	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		e - America k, White, e			
36	hours after death with the Maryland tural', or items 23a or 28a-f show al Exprimer must be rediffed at	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	l ☐ Yes 2 ☐ No	Specify:		Specify	: Bla	ack		
215-0036	be filed within 72 hours after death with the Marylan lal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examinatings be inclifted at		15. Decedent's E		16a Decer	ient's Usual Occupa	ation	1 1	16b. Kind of Bu	usiness/Ind	lustry		
Ċ	within 72 ene. than "nai	Completed	(Specify only highest gra	de completed)	(Give	kind of work done of OO NOT use retired	turing most of worl	king			,		
7	with iene. thar	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	Laborer	•		F	oultr	∼v		
Z.	filed Hygid Other ent, I	a	17. Father's Name (First, Middle, Last,					ne (First, Middle, M			4		
yland	should be fand Mental I s marked of umatic eve	To B	Elwood Fooks				Eliza S	turgis					
چ	shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	g Address (Street a	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)		
Mar	and 2 ealth a n 27 is		Peggy Briggs/daug	hter	804 3	rd St., S	eaford,	DE 19973					
ē,	- T 6 =		20a. Method of Disposition		20b. Place of Dispo	Company of the Compan			20c. Location -	City or To	wn, State		
Ë	Pages nent of int: If it		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		Fooks Fam		. 1	/2008	Berlin.	MD			
altimore,	- u -		21. Signature of Fine ral Service Lice		22	. Name and Addres	s of Facility			PIU			
ñ	permit. Depart Import any inj		InValled U	lasso	1	ewis N. W 618 West	atson Fu	neral Hon	ne /D 2180	1			
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not ent						Approximate Interval Between		
	Per Carton	g 11	onsediate Cause (Final										
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	YOMA				Te	WIEARS		
	Examiner				, , ,								
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):								
	outed ansit	Examin	that initiated events	c.									
Ď	an ar rial-tı		resulting in death) Last	Due to (or as	a consequence of):								
09/8	cate be executed physician and the burial-transit	dicai		_ d									
9	ng ph	a)	IF ECMALE.										
X R R	law requires that the death certificas been signed by the attending I s should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23d. Da	te of delive	ry Dav Year		
	dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown		Other (specify)			Mo	run	Day		
J.	at the	Phy	9 Unknown					co. Didust		alle conservation also			
	res tha igned l be det	by	Part II. Other significant conditions		14	, ,	en in Part I.				e cause of death?		
במ	w requir been si should i	ted	CORD HYP	ERTEYS19	ON DIAS	BETES_		1 ∐ Ye	s 2 No	3 Proba	ably 4 Unknown		
Hecords,	lawr as be 2 sh	Completed						24a. Was ar autopsy		Were autor	psy findings available inpletion of cause of		
	The ate ha	М						perform 1 ☐ Yes 2	red?	death? I □ Yes	2□ No		
VItal	Physician: The law this certificate has t ral director, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	9)				
5	hysic nis ce I dire	ဥ	Yes 2□No	Hospital: 1   Inpatie	nt 2 ER/Outpatier		4   Nursing H	ome 5 🗆 Reside	nce 6 □Oth	er (Specify	)		
		ü	27. Menner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui		28c. Injun Worl		28d. Describe ho	w injury occur	red			
<u> </u>	Attending or death, ector: After by the funer	cati	2 Accident investigatio			1	Yes 2□No						
DIVISION	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str City or Town		er or Rura	Route Number,		
	urs a								- 14->				
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical		niner: On the basis of	of my knowledge, deatl examination and/or in- ited								
	thin 2 the mplei	Med	29b. Signature and title of certifier	and manner sta	mod.	29c. License	e number	29	9d. Date signe	d (Month, l	Day, Year)		
	F 3 F 8	-	11 1 1	Sweetl M	S.		106241		4-04				
	Mos L		Jense my	7					, ,,				
	2 110		30. Name and address of person who	Completed cause of d		203 SNO	< <	nu. H.	Mo	0151	2		
	Sta	to	31. Date filed (Month, Day, Year)		ar's Signature	205 JARI	VSE, A	VOLU MICE,	11/1/	1.106	2		
	Registr		APR 0 7	2008	ar's Signature	المامي							

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

ICTUA

State

Registrar

Medical

29b. Signature and title of certific

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

determined

MD

and manner stated.

31. Date filed (Month, Day, Year) APR 02

4 ☐ Homicide

29a. Certifier

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4 PR16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUNRISE 1 VING If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Min. 1 □ M 2 🕅 F Days Hours Director 186-07-3441 93 4/16/1914 Pennsvlvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 → No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. Interest 23a or : marked other than "natural", or items 23a or : any or other traumatic event, the Medical Examiner must be a runy or other traumatic event, the Medical Examiner must be a runy. 1923 Hidden Point Rd. 21409 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 TWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u> Accounts Payable Clerk</u> Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Paravati Angelina Prestanacci 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelina M. Izzo/ Daughter 1925 Hidden Point Rd., Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 X Other (Specify) Entombment Gate of Heaven Cem. 4/5/08 Silver Spring, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fineral Service L 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** RENAL FAILURE ZMONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pł I for use as t IF FEMALE: 23c. If yes, outcome pt pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 mor 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) \\S\$15TeV Hospital: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manne of Death 1 ☑ Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Jepital C.
4 hours after dec.
7 meral Director: After dec.
7 in by the five within 24 hours a

Medical State

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date Med (Month, Day,

D46360

eterans HIGHNAY MILLERSVILLE MD 21/08

Year! APR 0 4 2008

and manner stated.

James Jerry Graves State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day March 30, 2008 2040 hrs **Medical Examiner** James J. Graves 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 11 Hicks Avenue Annapolis If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Country) Maryland Months Hours 25 1957 Director 220-68-5571 50 June  $_{1}X_{M}$ Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 4 1 1 X Yes 2 No items 23a or 28a-f show with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 11 Hicks Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Armed Forces? 1 Never Married Yes 2 X No Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify: Specify: **Black** "natural". þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "mat hijury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 12th O Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jane Lorraine Sims George Graves Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Md. 21401 Odetta Graves(Wife) 11 Hicks Avenue 20b Place of Disposition (Name of cemetery, Terematery of other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4-7-08 Annapolis, Md. Memorial Gardens Donation 5 Other Specify 2 Name and coesse f Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 100483 any 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** attending physician for use as the burial Records, P.O. Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown Completed peen : 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed' death? Yes 2 V No 2 No certificate 26.Place of Death (Check only one 25. Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> Residence 6 🗸 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Certification: Subject haged self FOUND: 24 hours after death

e Funer: I Director: A
letely filled in by the fu Natural Yes 2 V No Pending Mar 30, 2008 2030 hrs 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) 11 Hicks Avenue, Annapolis, Md determined (Specify) Single Family Homicid 29a. Certifier completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie **OCME** O.C.M.E. March 31, 2008 death (t m 23a) 30. Name and address of person who completed cau-Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR Q Registra

ORIGINAL

		1	For State Registrar	State of Maryland	d / Depa		lealth and l	Mental Hygi		12848
/M	/sicia ledica	n al -		nma Ge	eorge	41- 63- 1	Location of Docu	2. Date of Death Apr 10,	2008 Year	0103 M
Exa	amine		4a. Facility Name (If not institution, give Allegany County Nu	ırsing Home		Cumberl  If Under 1 Year	r Location of Deatl and If Under 24 Hrs.		Allegany	
Fune Direc			5. Social Security Number 6. Se 216-18-1217 6. Se 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (In yrs. I.	Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day, Jan 13,	1918	irthplace (State or Foreign
Maryland f show	led at		10a. State 10b. County Allegan		Cumb	cation erland				10d. Inside City Limits 1X Yes 2 □ No
with the 3a or 28a	1 De note	Direct	10e. Street and Number 819 Roeth Avenue			10f. Zip Code	21502	10	g. Citizen of What (	Country?
Baltimore, Inaryiand 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show	xaminar mus	Completed by Funeral Director	11. Maritat Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	
Baltimore, Maryland 21213-UU30 permit. Pages 1 and 2 should be filled within 72 hours alt Department of Health and Mental Hygiene. If Item 27 is marked other then "natural", or	Te Madical E	mpleted	15. Decedent's Edit (Specify only highest grad	(e completed)	16a. Deced (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired Clerk	ation during most of wo	rking	6b. Kind of Busines	·
/land /	ific evant, I	To Be Co	17. Father's Name (First, Middle, Last) Eugene Wade E				Cora E	ne <i>(First, Middle, M</i> liza Norris		
re, Mary	ır trauma		19a. Informant's Name/Relationship (7) Eugene Cramer	урв, Print) SON	19b. Mailir 1201	ng Address (Street 3 Nevada A	and Number or Ri VE. NW	ral Route Number, Cumbe	City or Town, State erland N	//D 21502
Ilmore, Pages 1 a Iment of He tant: If Item	Jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 1 ☐ Other (Specify,	//		osition (Name of matory or other place morial Park		4/13/2008	Cumberla	
Dan Depart Import	any in		21. Signature Fun val Service do				inia Avenu	e: Cumberla	and, MD 215	02
Priysic /Medi Exami	ical		23a. Part. Epfer the disease, or comp mock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line. aDue to (or as a consequ	TED	er the mode of dyin	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
<b>68 / 6U,</b> tificate be executed tg physician and	burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Under vin Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)						
Hecords, P.O. BOX 68.  The law requires that the death certificat the has been signed by the attending phy	ched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Urs 25 No 9 Unknown	23c. If yes, outcome of pregna 1  Live birth 2 Fetal 4 Pregnant at time of de	death 3[	□Ectopic pregnancy □ Other (specify)	/		23d. Date of d Month	lelivery Day Year
COTGS, P. w requires that	pe	۵	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		to the cause of death?  Probably 4 Unknown
	page 2	Completed						24a. Was ar autops perform 1 Yes 2	prior t death	autopsy findings available o completion of cause of ? es 2 \( \text{No} \)
OT VITAL P Phyaician: Th this certificate	<u>=</u>	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	er	ath <i>(Check onlv one</i> Home 5 ☐ Reside	a) nce 6 ⊟Other (Sµ	pecify)
VISION OF Attending Physic death.	e funeral o	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at	28d. Describe ho		
The second	ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
Hospital 24 hours a Funaral I	etely fills	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tirvestigation, in my o	me, date and place opinion, death occ	e, and due to the caurred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
To the within 2	compl	We	29b. Signature and title of certifier	01	. 6: 1	29c. Licens	e number		ed. Date signed (Mo H-1H-C	
			ame and address of person who	omplete cause of death (Item	23a) (Type,	Print)	- 1700 SD ALL	MARRIA	4ND, M	D 21502
Ro	Stat	_	31. Date filed (Month, Day, Year) APR 2 1 200	2. Registrar's Signa	ture	<u> </u>	<u> </u>	110070	HVIAII	V C10001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | 1 - For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0308 /Medical 4a. Facility Name (If not 4c. County of Death nstitution, give street and humber) 4b. City, Town, or Location of Death Examiner tto slumbia If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Days Hours 1 M 2 □ F Ione Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Tes No Completed by Funeral Director ind sor 10g. Citizen of What Country? 10f. Zip Code USA Circle Un+204 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes 2 No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if fem 27 le marked other than ' ary or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georges Pattin Denise 19a, Informant's Name/Relationship voe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Circle Unit 204 WindsorMill Denise Roberts (mother 20c. Location - City or Town, The 21244 Baltimore, 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation permit. Page Department o Important: If eny injury or once. 3 Removal from 4 Donation 3 Other (Specify) Hospital Howard County General Columbia MD 21044 21. Signature of Funeral Service Licenses 22. Name and Add ess of Facility eday Lane Columbia Manyland 21044 Hospital \bzl Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician norioann /Medical Due to (or as a consequence of): Examiner MODIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Year Month 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No After this certificate has been si funeral director, page 2 should I Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient filled in by the funeral ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28a. 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation death. 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ittle Patient Blumy Mio 11085 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0250 HOOVER THOMAS April 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Co. Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months 1**∑** M 2□ F Days Yrs 214-09-7028 Director 93 10,1914 Maryland Dec. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hyglene.

marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20509 Shaheen Lane 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. <u>چ</u> 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aircraft Mfg. 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important; If Item 27 Is marked other
any injury or rether. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon R. Hoover Violet Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Hoover, Jr. / Son 20509 Shaheen Lane Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Apr.7,2008 Hagerstown,MD 22 Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N, Hagerstown, Md 21742 21. Signature of Funeral Service Licensee ) unda A 23a. Part1. Enter the isease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic 2 day **Physician** /Medical Due to (or as a consequence of): Examiner Metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural

Accident 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

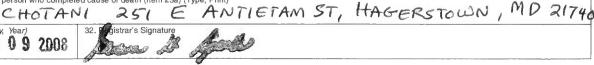
3H-4

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State

Registrar

29c. License number

D58853

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month 6:37 P.M 03 2008 David 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Conter Westminster Carroll Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) North Carolina (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 359-24-1073 Director 05/14/1930 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 XNo MO Carroll Westminster Funeral Director 28a-f 10e. Street and Number 10g. Citizen of What Country? ms 23a or old Hanover Road 4211 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 'natural", or items 11. Marital Status Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner ones. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Floral Horticulturalist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hughes Emma Davis ပ 19a. Informant's Name/Relationship ype. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4211 Old Hanover Rd., Westminster, MO 21158 Nora (Davis) Hughes 20b. Place of Disposition (Name of cemetery, crematory or other place) Jefferson Keylvel Free 20a. Method of Disposition 4/4/2008 Jefferson, PA 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) BAPTIST Church come. 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Stephen Wetzel Funeral Home Hanover, PA 17331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AILURE Physician RESPIRATORY /Medical **Examiner** NEUMONIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician al the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RHEUMATOID ARTHRITIS 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 22 No Hospital: Other: pital: Inpatient 28a. Date of Injury 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: (completely filled in by the f 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ှိ WJL 30263

Registrar
DHMH 17 Rev 1/2001

State

10

FRANCIS

31. Date filed (Month, Day, Year)

200 MEMORIAL AVE

WESTMINSTER, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regitrar's Signature

KHOO,

APR 0 3 2008

Division or Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and

			Please Type or						•	
			1 - For State O	ı ıvıaryıan	-	nent of A icate of L	ealth and N		67 M	45
			Registrar  1. Decedent's Name (First, Middle, Last)		Certii	icate of L	Jealii	2. Date of Dea	leg. No.	3. Time of Death
	Physicia /Medic	al	Della			ston	Lacation of Dooth	Month April	Day Year 200	08 11:52 AM
	Examin	er	4a. Facility Name (If not institution, give street and nur	nber)			Location of Death		4c. County of Dea	tn
	uneral irector		5. Social Security Number 6. Sex 1 M 2 TF	7. Age (In yrs.	last birthday)lf	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day July 1	1 9. Bir	thplace (State or Foreign ountry)
pur	8	}	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location	on				10d. Inside City Limits
Maryla	ied at	tor	Maryland Anne Arundel		hurchto					1 ☐Yes 2 <b>X</b> No
th the	or 28g	Director	10e. Street and Number		1	0f. Zip Code	-		10g. Citizen of What Co	ountry?
th wit	23a c	al	5880 Shady Side Rd.			2073	33		USA	
ar dea	tems er m	Funeral	Armed Fo		S. 13. Was	Decedent of Hi s, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 ☐ Never Married	/e	1 🗆	Yes ሺ No	Specify:		Specify:	Black
<b>5-0</b>	natur fical I	sted	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent	's Usual Occupa	ation	ina	16b. Kind of Business	/Industry
	han " e Mec	Completed	Elementary/Secondary (0-12) College (1				furing most of work )	9	Children.	a Hoanital
Iled w	nt, th	S	12th 2yr	5	INI	ırse	18. Mother's Nam	e (First, Middle,	Maiden Surname)	s Hospital
Maryland d 2 should be file th and Mental Hy	fitem 27 is marked other r other traumatic event, the	To Be	Joseph Fluellyn				Jean I			
aryla   should   and Men	s пап		19a. Informant's Name/Relationship (Type. Print)		19b. Mailing A	ddress (Street a	and Number or Rui	al Route Numbe	r, City or Town, State,	Zip Code)
B, Mis and 2	n 27 i ier tra		Reuben Hairston(Husb				Side Rd.		chton, M	
more Pages 1	If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from		lace of Disposition			Date	20c. Location - City or	
altimore, rmit. Pages 1 a	rtant: njury		4 Donation 5 Other (Specify)	Ме	tro Cre	_			Baltimore P.A	
<b>Gan</b>	Important: Il any Injury o once.		21. Signature of Funeral Service Licensee  Tarry H. Reese Moc	483					, Md. 21	
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the deatl ach line.	n. Do not enter th	ne mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner			umania						
			Pan	or as a consequence	uence of):					
# 5		ner	Sequentially list conditions	or as a conseq	uence of):					
<b>6U,</b> be executed	and transi	Examiner	that initiated events	or as a consequence	Hepatoco	Hular Co	uncer			
	sician a	70	Due to	or as a consequ	defice of).					
<b>58</b> Ifficate	g phy as the	edic	u							
ecords, P.O. Box 687	y the attending physician and ched for use as the burial-transit	Physician/Medic	in the past 12 months?	come pf pregna pirth 2 ☐ Feta pant at time of d pown	I death 3 □Ect	topic pregnancy her (s <i>pecify</i> )			23d. Date of de Month	livery Day Year
s that	ned b	by Pr	Part II. Other significant conditions contributing to de	eath but not res	ulting in the under	rlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of death?		
ords equire	been signed by the should be detached							1 🗆 🗅	′es 2⊠No 3⊟P	robably 4 Unknown
VITAI KECORUS, sician: The law requires t	has be ge 2 sho	Completed				_			sy prior to med? death?	utopsy findings available completion of cause of
ta ⊒∷ ⊥	certificate has birector, page 2 s		25. Was case referred to medical				26. Place of Deat		2⊠No 1 ☐ Yes	s 2□No
	is cer direct	To Be	examiner?	npatient 2	ER/Outpatient	3 DOA Othe	or:		lence 6 DOther (Spe	ecify)
on or	h. : After this certifica : funeral director, p	tion: 1	27. Manner of Death  1 Natural 5 Pending (Mon 2 Accident investigation	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	
UIVISION ( al or Attending F after death.	ire <b>ctor</b> ו by the	Certification:	3 Suicide 6 Could not be 28e. Place	of injury - At ho ng, etc. (Specif	ome, farm, street,	factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
the Hospital	To the Funeral D completely filled in		29a. Certifier 1 ☑ Certifying Physician: To the (Check only 2 ☐ Medical Examiner: On the b							
Fo the Pwithin 24	o the F	Medical	one) and man 29b. Signature and title of certifier	ner stated.		29c. License	e number		29d. Date signed (Mon	th. Day. Year)
F 3	2 2		Muril m. Ja	Rece		Doo	66778		4/2/2	
74	H		30. Name and address of person who completed cause Micole Fuzzer, Johns	المصل	as Harait	rd 6000	N. Woiks	t. Balt	none 2126	7
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) 32. F APR 0 4 2008	e strar's Signa	ture					
DUMUA	7 Pov 1/2		4 1 2000	Colles.	A Am	w				

State of Maryland / Department of Health and Mental Hygiene 📿 🕕 🦰 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month APRIL HOROWITZ **Physician** 1757pm 2008 UGENE /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** MONTGOMER HOSPITAL OLNEY MONTGOMER' GENERAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F District of Columbia August 5, 1936 Director 217-32-0731 Usual Residence of Decedent iled within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "netural", or Items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2 🔀 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3200 North Leisure World Blvd., #502 20906 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: Completed by 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Hygiene 4 Administrator Food marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other eny injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Horowitz Frances Koenick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Horowitz - Wife 3200 N. Leisure World Blvd., #502, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/04/2008 Judean Memorial Gardens Olney, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Co 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UREMIC **Physician** HEMOLYTIC /Medical Examiner S Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner and d-transit The law requires that the death certificate be executed physician a s the burial-Physician/Medical IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospitaf: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert Certification: To the Hospitel or Attending 1 Naturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 9 Surun Mr. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe Street, Park Bldg 207 ADEWUNM MYEMI Baltimore, MD 21287 32 Registrar's Signature 31. Date fifed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

04

Maryland 21215-0036

Baltimore,

o

۵.

Records,

Division of Vital

08-02820 Lav

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

wrence D. Hull	1-	State of Maryland / Department of Hea For State Certificate of Dea		riygierie Reg. f	201	08 128		
Physician		egistrar I. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death		
edical Examin		Lawrence Duane Hull		Month Da April 10, 200	8	1758 hrs		
(a	4	A delity Name (if not institution, give object and	y, Town, or Location of Dea napolis	ath	4c. County of Death Anne Arundel			
		317 Tucker Officer	nder 1 Year   If Under 24h	Hrs. 8. Date of Birth(N	MM/DD/YYYY) 9. Birth	nplace (State or		
Funeral Director		521-42-4588 1XM 2 F 73 Yrs. Moi		12/6/1	Foreign	California		
any	_	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits		
<b>*</b>		unknown unknown unknown				1 Yes 2 No		
Maryland 28a-f show d at once.	ᅙ		Zip Code	10g.	Citizen of What Coun	try?		
th the Maryland 23a or 28a-f sho	Director	unknown	unknown		USA			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Menial Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ᇎ	1 Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,		
fter de		3 Widowed 4 X Divorced If Yes, Give Year 1953-67	2 X No specify:			ite		
ours a	٩	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Us	ual Occupation (Give kind working life. DO NOT use	0	6b. Kind of Business/I	ndustry		
6 72 h an "n al E	eted	Elementary/Secondary (0-12) College (1-4 or 5+)  Very Self Em	nlovod		Art			
withir jene.	dwo	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medie	Š B	Ernest Hull		Lois Small				
212 ould be Menta mark ic even	8 2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Addi	ress (Street and Number	or Rural Route Number	er, City or Town, State	, Zip Code)		
MD and 2 show alth and 2 is aumati	7	Bind of Oldin, Badonool	ttiz Ave., I		CA 90815	<del>-</del>		
e, Pand I and Healt I item	1	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (crematory or other pl.		Date	20c. Location - City or	Town, State		
Pages ent of nt: It	- 1	I Kalas Crema	itory	4/15/08	Edgewater	, MD		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	ı	21. Signal, re of Fun ral in rvice Licensee 22. Name	and Address of Facility					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	Solomons Is	SLand Kd. I	dgewater,	MD 21037 Approximate Interval		
Physician i al		failure Liet only one cause on each line				Between Onset and		
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cadiovascular Due to (or as a consequence of):	c disease compi	icating esopi	lagear Carcin			
	2	Sequentially list conditions, if any, leading to immediate b.  Lue to (or as a consequence or,)						
	Ē	cause. Enter Underlying Cause						
ed nsit	edical Examiner	events resulting in death) Last d. Due to (or as a consequence of):						
50, te be executed ysician and burial - transit	ह		TITE					
30, ate be a specie		UNPENDED  AMENDED  AMENDED  AMENDED  7, perME, 8879 5/7/08 1	11		23d. Date of delive	•		
Box 6876 death certificate the attending phy	sician/M	23b. Was decedent pregnant in the past 12 months?		regnancy	Month	Day Year		
OX 6	sici	past 12 months?  4 Pregnant at time of death 5 Other  1 Yes 2 No 9 Unknown g Unknown	(Specify)					
b. B. the de ched f	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I		acco use contribute to			
ords, P.O. w requires that the as been signed by t should be detache	ξ			1 Yes	2 No 3 Pro	bably 4 V Unknown		
ds, equire	Completed			24a. Was a autops		utopsy findings available completion of cause of		
COF law r has b e 2 sh	Jd II			perform	ned? death?			
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical	26.Place of Death (Cl					
/ital sician is cert	Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other	Nursing Home 5 F	Residence 6 🗸 Oth	er: Scene		
of V ing Phy After th	<u>۱.</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		li i	ow injury occurred			
OD on ath.	tior	Natural 5 Pending	1 Yes 2 N					
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should!	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ical Ce	4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred (Check only one)  2 ✓ Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place in my opinion, death occu	e, and due to the cause irred at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)		
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M			
		16/100	O.C.M.E.		April 11, 2008			
		30. Name and address of person who completed cause of death (Item 23a)			<u> </u>			
141/10		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MI	D 21201				
S	tate	1/1/1/1/1/5////////////////////////////	A					
Regis				OCME				
DHMH 17 Rev 1/2	001	ORIGINAL						

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Mar		artment of H		nd Mental Hyg	giene	12255	
	9 - 3	e e	Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death	
1	Physici /Medic		Eileen S. Hvizda					Month 4/1	/2008 Year	11:27pm	
	Examir		4a. Facility Name (If not institution, give :			4b. City, Town, or	-	Death	4c. County of Dea		
		#	5852 Swamp Circle			Dea.	Le  If Under 24	Hrs. I o D		Arunde1	
	Funeral Director		5. Social Security Number 6. Security Number 112	7. Age (	(In yrs. last birthday) 61 Yrs.	Months Days		Min. 8. Date of Birtl Month, Pay 8/12/1	7. Year) 9. 81 946	rthplace (State or Foreign country)  DC	
3.54			Usual Residence of Decedent					0/12/1	J40	DC	
	ylanc how		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. fnside City Limits	
	Ba-f	cto	MD Anne Aru	inde1	Deale					1 ☐ Yes 🏖 XINo	
	in th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?	
	s 23s	Funeral	5862 Swamp Circle			207		2/2 / //	USA	- dans to disc	
	item item	une	11. Maritaf Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H f Yes, specify Cuba	lispanic Origin an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh		
39	hours after death with the Maryland tural', or items 23a or 28s-f ehow al Examinat must be notified at	by	3 Widowed 4XDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White	
2-0	d within 72 hours after death with the Marylan jene r then "natural", or items 23a or 28a-f ehow The Madical Examinet must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	ation	f working	16b. Kind of Busines	s/Industry	
21	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	ddiing most o	WOIKING			
21	e filed within al Hygiene. I other then 'vent, the Ma	Co	12		Bart	ender			Restau	rant	
and	0 = 0	Be	17. Father's Name (First, Middle, Last) William James Coll	4-0				Name (First, Middle,	,		
Maryland 21215-0036	s 1 and 2 should be f Health and Mental litem 27 is marked of other traumatic even	2	19a. Informant's Name/Relationship (Ty		19h Mailin	n Address (Street		en S. Smitl	n. r, City or Town, State,	Zin Code)	
Ma	d 2 7 tra			on		nwall Ct		apolis, MD		Zip Code)	
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	7	Date	20c. Location - City o	r Town, State	
E O	Page: ent o nt: if ry or		1 ☐ Burial 2X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Metro Cre	natory`or other plac matory		/5/2008	Baltimore	• MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other ance.		21. Signature of Funeral Sergice License			•			ineral Home		
m	88 E 8		10 9.00		12	Ridgely	Ave.	Annapolis	MD 21401		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not ent	er the mode of dyin	ig, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between	
	Physician		tmmediate Cause (Final disease or condition resulting in death)  a. Small Cell Ung Cancer  ung Cancer							Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		J				
		10	Sequentiatly list conditions, if any, leading to immediate		consequence of):						
	nsit	Examine	cause. Enter Underlying Cause (Disease or injury								
,	sician and burial-transit	Exai	that initiated events c.  Due to (or as a consequence of):								
8760,	death certificate be executed e attending physician and id for use as the burral-transit	dicai	d								
9	ntifica ng ph as th	ledi	IL CENTILE.								
Box	eath certific attending p	Physician/Me	230. Was decedent pregnant	3c. ff yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy	,		23d. Date of de		
	se dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown		Other (specify)			Month	Day Year	
P.0	by lac		Part II. Other significant conditions cor	atabuting to death but	not resulting in the ur	nderhing cause and	en in Part f	23e Did to	bacco use contribute	to the cause of death?	
Vital Records,	es ign be	d by	, u	in batting to doubt batti	not rosuming at the di	identying cause givi	on an ant.	\.		Probably 4 Dunknown	
cor	> 0.0	Completed						24a. Was :	24h Were	autopsy findings available	
Re	The law ate has b page 2 st							autop perfor	sy prior to med? death?	completion of cause of	
tal		0	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only or	7	s 2 No	
	Physician: this certific ral director,	To B	examiner?	lospital: 1   Inpatient	2 ER/Outpatien	t 3 DOA Oth		1 -	ence 6 Other (Specify)		
			27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe h	ow injury occurred		
	Attending r death. ector: After by the fune	catle	2 Accident investigation			M 1 🗆	Yes 2□No				
	il or Attend after death   Director: / d in by the f	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route of City or Town, State)						Rural Route Number,		
	Hospital or 24 hours afte Funeral Dir stely filled in I		29a. Certifier 12 Certifying Phys	sicien: To the best of	my knowledge death	occurred at the time	ne date and r	place, and due to the	Causa(s) and manner	ne stated	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		ner: On the basis of each	kamination and/or inv	estigation, in my o	pinion, death	occurred at the time,	date and place, and du	ie to the cause(s)	
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Mor	nth, Day, Year)	
			I feare i	ver-	MO	DS	2835		April 2	2008	
0	110		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print)		12		1	
8	9+		Jeanine Wer	e, 400 B	sestgak 1	wad #	، حدد	thnapoli	SMO	21401	
	Sta Registr	100	31. Date filed (Month, Day, Year) APR 0 3 20	32. Fegistrar's	s Signature	and a	/		)		
41.4	ricgioti	ш	11111 4 0 50	- July	- ~ ~						

7 DHMH 17 Rev 1/2001

State Registrar MI

32. Registrar's Signature

902 Seton Dr Suite 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNONI

AN ITA

31. Date filed (Month, Day, Year)

			_				K. Ensure All Health and M		7 (1)	3   2857	
			1 - State Registrar		•	Certificate of		Reg.			
			1. Decedent's Name (First, Middle, Last	)				2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medio		ELLEN HO	WIE HO	LTGREN			April	1, 2008	10:30P <sup>M</sup>	
		xaminer  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							4c. County of Dea	ath	
			Mancare Health	Service	es	Chev	ey Chase	O. Data of Disth	Montgo	mery	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Onder 1 Hair 11 Onder 24 His. 8. Date of Birth 9. Birth Court 1 Divided 24 His. 8. Date of Birth 9. Birthg Court						rthplace (State or Foreign ountry)		
	-		154-10-8973 Usual Residence of Decedent	Λ	0 /			глятА 77	,1920 S	Scotland	
	nylan Ihow	_	10a. State 10b. County		10c. City, Town	or Location				10d. inside City Limits	
	Ba-f.	Director	VA Loudou	ın	Ster					1 ☐ Yes 2 🔀 No	
	vith the	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?	
	hours after death with the Maryland Lural', or Items 23a or 28a-f ahow at Examinar must be netified at	erai	704 South Birc	h Street	Ever in 11 S	201		acify Vac or No-	U.S. of	A Indian	
_	fter d	Funeral	1 □ Never Married 2 □ Married	Armed Forces?		If Yes, specify Cu	f Hispanic Origin? (Spe ban, Mexican, Puerto	Rican, etc.)	DIACK, VVII	ile, etc.	
3	al', o	Ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:			1 ☐ Yes 2☐ No Specify:			Specify: White		
15-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-1 ahow circal Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			Decedent's Usual Occ	e during most of work	ina 16t	o. Kind of Business		
7	d within 72 piene. r than "nat	μ	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use reti	red)				
7.5	filed v Hygie other t	S	17. Father's Name (First, Middle, Last)		1	Homemake		e (First, Middle, Mai	Own Ho	me	
⊆	e da pa	o Be							inte (i iist, widdle, walden Samane)		
ar	2 should to and Ment is marked raumatic of	2	Samuel  19a. Informant's Name/Relationship (T)	уре, Print) МСК	Kain 196.1	Mailing Address (Stre	Mary et and Number or Run	HOWIE al Route Number, C	ity or Town, State,	Zip Code)	
Š	면들었다		Pamela Mary Ho	ltaren/D	aughte	r 704 S.	Birch St	reet St	erling.	VA 20164	
more,	es 1 a of Hez fitem roths		Pamela Mary Holtgren/Daughter 704 S. Birch Street Sterling, V. 20a. Method of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Tow							r Town, State	
Ĕ	Pages nent of ent; if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		•	2rematory	A A	lexandr	ia,. VA	
žali	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	99		22. Name and Add	lress of Facility	udoun_F	unoral	Chanels	
_	205 # g		Chilliany/Mells		C0419	158 Cato	octin Cir	cle, SE	, Leesb	urg, VA Approximate	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Physician /Medical		Immediate Cause (Final disease or condition a. Multiorgan Failure resulting in death)						Onset and Death Months		
	Examiner		Due to (or as a consequence of):							20 1 2-	
	$\pm \pi$	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sepsis	a consequence of	).				Month	
	d d ansit	Examin	Cause (Disease or injury that initiated events Anemia						Weeks		
ρŋ,	eath certificate be executed attending physicien and for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):								
9	ate be hysici	Ical	0.								
200	ertifica ling pl	Med	IF FEMALE:								
X Q Q	requires that the death certificate een signed by the attending phys nould be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1					23d. Date o Month		f delivery Day Year	
j.	the de	ysic									
ř.	res that the de signed by the a l be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
	quires n sign ald be	d by	Dementia				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk				
1	> 0 2	Completed	Demener	u				24a. Was an	24b. Were a	utopsy findings available	
ř	The It	Шo						autopsy performed	d?   death?		
Nital Vital	ien: rtifice stor. p	Be C	25. Was case referred to medical				26. Place of Death	(Check only one)	INO TELE	3 20110	
>	hysic his ce I direc	ToE	examiner?					Home 5 ☐ Residence 6 ☐ Other (Specify)			
VISION OF	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?					injury occurred		
	Itand death tor: / the fi	ertification;	2 Accident investigation 3 Suicide 6 Could not be		☐Yes 2 ☐No	206 Landing (Ctoo	Location (Street and Alumber on Count Plants Number				
$\leq$	or Al after of Direction by	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)			n, street, factory, offic	treet, factory, office 28f. Location (Street City or Town, St			it and Number or Rural Route Number, State)	
	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate hes completely filled in by the funeral director, page 2 a	O	29a. Certifier 1 X Certifying Phy	sician: To the best of	of my knowledge	death occurred at the	time, date and place,	and due to the caus	e(s) and manner a	as stated.	
	P Fur	edical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and	or investigation, in my	opinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	1 D		29c. Lice	nse number	29d.	29d. Date signed (Month, Day, Year)		
			Raugel K Tuli				D19609 4.			1.3.08	
	10		30. Name and address of person who co	pleted cause of d	eath (Item 23a) (T	ype, Print)					
	Ψ		Raman Tuli, MD 31. Date filed (Month, Day, Year)	10810 Da	rnestov	m_RD#202	, Gaith	ersburg,	MD 208	378	
114	Sta	te	31. Date filed (Month, Day, Year)	32. Hegistra	ar's Signature	1 Smarth 1					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 01-2009 8:20 AM Shirley Loreman Heslop $\bigcirc$ $\Box$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sq\iSbury If Under 1 Year | If Under 24 Hrs Wicomico Hospice at the Lake Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F 83 Feb. 8, 1925 South Dakota Director 504-12-6424 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 503 N. Pinehust Avenue 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Ira Anderson Gertrude Barbara Schmidt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health at Important: If Item 27 Is any injury or other trauonce. Barbara E. Loreman/Daughter 503 N. Pinehurst Avenue, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State 4/4/2008 Wicomico Mem. Park 4 ☐ Donation → 5 ☐ Other (Specify) Salisbury, Maryland 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 21. Sig ture of Fr neral Service Lic Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONHRY DRSEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 Yes 22 No 9 Unknown Year Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an autopsy perform 200 Ro 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mayner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide determined

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, hours after death.

Ineral Director; After this y filled in by the funeral di Hospital or Attending within 24 hours a To the Funeral L

23a or

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-01-08 00058410

6 Huntu WANG State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HOSPICA

10 BOX 1733 SALISBURY NO 21802

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Apri Thomas O. Hill, Sr. 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata harles Center 8. Date of Birth (Month, Day, Year) June 5, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 1 □ M 2 □ F North Carolina Director 240-22-0594 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 Yes 2 □ No Director Charles Indian Head Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 48 Greenwood Place 20640 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Specify Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Pages 1 and 2 should be 1 nent of Health and Mental Andrew E. Hill Susan Lawrence 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5425 Indian Head Hwy., Indian Head, Md. 20640 Thomas O. Hill, Jr. son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 7, 2008 20c. Location - City or Town, State 20a. Method of Disposition Important: If its any injury or o once, ¶ Burial 2 □ Cremation 3 □ Removal from State Indian Head, Maryland 4 Donation 5 Other (Specify) St. Charles Cemetery 22. Name and Address of Facility
Williams Funeral Home, P. A.
4270 Hawthorne Rd., Indian Head, Md. 20640 21. Signature of Funeral Service Licer M00668 23a. Part1. Enter the giseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Physician SIS /Medical Due to (or as a consequence of): TWFECTION Examiner TRACT Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 □ No Ö the 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? signed the det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 9 - METASTATIC CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CHEMOTHERAI 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? has certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: '☐inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manner of Death Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ashvin

Patel

DHMH 17 Rev 1/2001

Mellon

AHENIN

Eleve & Spark

102 Paul 1 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Suite 102 Waldorf MD 20602

amened item #5/webd/4-11-08/man elible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 **Physician** April 1, Susan Esther Joseph 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eden/Allen Road Eden Somerset If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 221-24-2**439**2 Days Hours 1 □ M 2 7 F 70 Director 7/7/1937 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be availabled. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Wicomico Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 31650 Dilworth 21804 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Granville Smith Mildred Ross 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30927 Eden/Allen Rd., Eden, MD 21822 Phil Joseph/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4/4/08 Salisbury, MD 4 Donation 5 Dother (Specify) Funeral Service nsee <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Asso 501 Snow Hill Rd., Salisbury, MD 21804 Association a. Part Enter the disease, or complications that shock, or heart failure. List only one cause on Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Fuilvre **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate 1∐ Yes 2 No or Attending Physician; director. Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home of 1 Inpatient 2 ER/Outpatient 3 DOA Son funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pendina investigation 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Passeri, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

31575 Winterplace Parkway, Salisbury, MD 21804 32. Rafistrar's Signature

Registrar APR 03 2008 29c. License number

MO

000 609 58

29d. Date signed (Month, Day, Year)

413108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 31 2008 5:45 Margaret Rouse Kelvey /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Lookabout Manor Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F NJ Director Apr 24 1930 159-26-1085 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1510 Stone Road 21158 <u>USA</u> Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Hoskins 2 Joseph Rouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 21157 Robert Kelvey/husband 1351 Alumni Drv 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Branch Cemetery 04/04/2008 Westminster, MD 4 Donation 5 Dother (Specify) 21. Signatur, o Pineral Prietro Forer alimnome and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNK **Physician** /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. 9□Unknown the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to completi death? 1 ☐ Yes 2, ☑ director, page 2 perform certificate | 2,**N**0 Division or Vital 25. Was case referr to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Tyes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec P this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medigan Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of cel 29c. License number 29d. Date signed (Month, Day, Year) 33595 WJZ 123a) (Typehin) ip Ruzbarsky, MD 4 eath (Ite on who completed cause of 30. Name and address of per 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 02

2008

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

	•	For State Registrar	S	State o	of Ma	rylan	d / Depa <i>Cer</i>		nt of H ate of I			lental		ene2	008	1	2862
Physicia		1. Decedent's Name (First, Midd	#150 F									Monti		Day 31	Year <b>2008</b>	3. Time	e of Death
/Medic Examin		FLOYD KRA  4a. Facility Name (If not institution	AMER n. give stre	et and no	umber)			4b. Cit	y, Town, or	Location	of Death	MARC	л		ty of Death	12:	23
⊏Xanıııı	er	Southern Mary						C1	intor	1				Princ	e Geo	rges	
Funeral	0	5. Social Security Number	6. Sex	2□F	7. Age		ast birthday) Yrs.		er 1 Year	If Under Hours	Min.		of Birth	Year)	9. Birthp	lace (Sta	te or Foreign
Director		159-28-0634 Usual Residence of Decedent			73	}	110.					May	24,	1934	PA		
land ow It		10a. State 10b. County	,			10c. City	, Town or Lo	cation							1	0d. Inside	City Limits
Mary -f sh ied a	ţō	MD Prince	e Geor	rges		C	1inton									1 □ Y	es 2⊠No
r 28a	Director	10e. Street and Number						10f. Z	ip Code				100	g. Citizen of	f What Cour	ntry?	
h with		9201 Pineview	Lane						20	0735				USA	A		
deat ms 2	Funeral	11. Marital Status		Was Dec		ver in U.	S. 13. \	Vas Dec	edent of H		igin? (Spe	ecify Yes	or No-		ace - Americ		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If time Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced			2 XN Give	0		_	2 X No	Specify:		rican, or	J.)	Spec			
2 hou	ed 1	15. Deceder	l nt's Educati	ion	-		16a. Deced	lent's Us	sual Occup	ation			16	6b. Kind of		ite dustry	
hin 72 In "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade co	ompleted College		F)	(Give life. L	kind of v OO NOT	vork done d use retired	during mos t)	st of worki	ing					
d with	mo.	7th				·	Handi	сар	Trans	sport	ation	n Dri	ver	Wash.	Hosp	ital	Cente
al Hy lothe vent,	Be	17. Father's Name (First, Middle	Last)							18. Mothe	er's Name	(First, M	liddle, Ma	aiden Surna	ame)		
Ment Ment arked	2	Wilmer Wolf H	Krame	r						Ве	rtha	м. п	etwe	eiler			
2 short and land land land land		19a. Informant's Name/Relations		,				_						City or Tow	n, State, Zip	Code)	
and lealth m 27 her to		Barbara Kramer	c/Wife	e		Jook D			eviev			linto			0735		
ges 1 If of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Rem	oval fron	n State		lace of Dispo emetery, cren	-		1		Date		0c. Location			
t. Pa tmen tant:		4 □ Donation 5 □ Other (				Riv	erdale						Ri	iverda	ale, M	D	
permi Depar Impo any fr		21. Signature of Funeral Service	Licensee	///	att	5)			and Addres ly Fur Georg				Jachi	ingtor	n DC	2001	1
1000		23a. Part1. Enter the disease, o	complicat	tions that	caused	the death			-						1, 50	Approxir	
Physician	5 (	shock, or heart failure. Lis Immediate Cause (Final	t only one o	cause on	each line	e. ≰∆ ∠	10	D A	14.2	na ton		1	21/1	126	10	Onset a	nd Death
/Medical		disease or condition resulting in death)	a	Due to	o (or as a	consequ	uence of):	1	3//21 0	710	7		17 10	( / C			
Examiner		Sequentially list conditions	b				Sep.	Siz									
p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Į	Due to	o (or as a	consequ	uence of):	_	-		1	1.4					
and -trans	Examine	that initiated events resulting in death) Last	C	Duate	× 41	1 "	rence of):	Dv	rude	mal	4	1164	2				
cate be executed physician and the burial-transit				Due to	/ (or as a	00113646	derive ory.										
icate phys s the	dical		d														
The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, or										23d. D	ate of deliv	erv	
death s after	cial	in the past 12 months? 1 □ Yes 2 □ No		4□Preg	gnant at t	2 ☐ Fetal time of de		JEctopic Other (	pregnancy specify)	′					Month	Day	Year
t the oy the achec	hysi	9 Unknown		9□Unk	nown												
s tha	by P	Part II. Other significant condition					0		_	en in Part i	i.	23e.	Did toba	acco use co	ntribute to t	he cause	of death?
en sig		Metabolic		Cld	080	5'	Puls	6/6	22	Rt	169		1 Yes	2 □ No	3 ☐ Prol	ably 4	□Unknown
has be	Completed	Choonic	Obs	tru	chi	VD	14300		1/50	onsi	01	24a.	Was an autopsy	24b	. Were auto	psy findin	gs available of cause of
	mo;	SEVERE		0) 20 /	337	10	. Ki	dn	0 y 1	Kon i	IXE	10	perform	ed?	death?	2 □ No	n cause of
ician: Th certificate ector, pag	Be	25. Was case referred to medica examiner?				,		-1	7 1	26. Place	e of Death	n (Check					
Physic this ce al dire	To	1 ☐ Yes 2 No		pital: 1			ER/Outpatien	t 3□[	OOA Oth	er: 4□Nu	ursing Ho	me 5 🗆	Residen	nce 6 □O	ther (Specia	<i>5y)</i>	
Ing P		27. Manner of Death  1 XNatural 5 ☐ Pendii		28a. Date ( <i>M</i> o	e of Injury onth, Day		28b. Time of Injury		28c. Injur Worl			28d. Desc	cribe how	v injury occi	urred		
tendleath.	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation	0.0 DI				M		Yes 2 🗌							
i or At after d Direct J in by	Certification:	4 Homicide determ		28e. Plac buil	ding, etc.	ry - At no . <i>(Specif</i> y	ome, farm, stro y)	et, fact	ory, office		1	28f. Local City o	tion (Stre or Town,	eet and Nun State)	nber or Run	al Route N	umber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	calC	29a. Certifier 12 Certifyi	ng Physici	ian: To th	ne best of	f my knor	wledge, death	occurre vestinati	ed at the tir	ne, date a	nd place,	and due t	o the cau	use(s) and r	manner as s	tated.	se(s)
the H iin 24 the F	ledical	one)			nner stat						ain occur	iou at tire					
To COT	Σ	29b. Signature and title of certific	110			a A		2	9c. Licens	-0	125			d. Date sigr			
		On Name and Citizen	47	Notari as	100 Ct 4-	oth (line	220) (Time	Drint\	V	280	753	D:-		1010	ch 3	500	008
4		30. Name and address of person						77. C	,	C1.	しかり	(1)	800	itan D2	643	5	#310
Sta	te	31. Date filed (Month, Day, Year APR 0 4 2008	6	32.	Registra	r's Signa	ture										

	_	
State of Maryland / Department of Health and Mental Hygiene	0	0
Contificate of Dooth		

			For State Registrar	State o	f Maryland		rtment of tificate of		Mental Hygie	ene2 () () () g. No.	12863
	×5		1. Decedent's Name (First, Middle	Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Charles	W	•		Kramer		March 26		8:15p M
	Examin	_	4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Town,	or Location of Dea	ith	4c. County of Dea	th
			14621 Brough					Potomac		Montgome	ry
	Funeral			6. Sex 1 X M 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	rear) Co	hplece (State or Foreign buntry)
	Director		145-38-3971 Usuel Residence of Decedent			115.			Feb. 15,	1947   Nev	York
land	Mo III		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
Many	분절	ţ	Maryland Montgo	mery	Nor	th Pot	omac				1 ☐ Yes 2 🔀 No
the	r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?
h wit	23a o	O E	14621 Brougham	Way			20878		1	United Sta	ites
deat	E E	Funerai	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	S. 13. V	Vas Decedent of	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No-	14. Race - Ame Black, Whit	ncan Indian,
after o	P E	교	1 ☐ Never Married 25 Marri		2 ☑ No		Yes 2√2 No		110 1 110411, 010.)	Specify: Whi	
Super	Lend,	d by	3 Widowed 4 Divorced	Year or D							
721	net.	Completed	15. Decedent (Specify only highes			(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of we	orking	6b. Kind of Business	Industry
with A	then the	Ĕ	Elementary/Secondary (0-12)	College (1	1-4or 5+)				7 - 7		
	Hygi ht.	CO	17. Father's Name (First, Middle, I				ALL	orney at	Law ame (First, Middle, Mi	legal aiden Sumame)	
d be fil	ental ked c	To B	Abraham Kramer					Evelvn	Goldstein		
shou	mar mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Stree	1	Rural Route Number,	City or Town, State, .	Zip Code)
and 2	elth a		Wendy Kramer-sp	ouse		14621	Brougha	m Way, N	orth Poton	nac, MD 20	878
8 . G	of He		20a. Method of Disposition	2	20b. PI	ace of Dispo	sition (Name of natory or other pla	ice)	1.	0c. Location - City or	
mit. Peges	ant: h		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		oln Crem	' / / / /	/2008 I	Brentwood,	MD
emit.	Depertment of Heelth and Mental Hygiene. Important: If Item 27s or 28a-f show Important: If Item 27 is marked other then "neturel", or Items 23s or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Furral Service L	icense.	1				mple Tribu		
<b>a</b> &	0599	. 23	Ce Im Ju	sch-Im	dy				ke, Rockvi		0852
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	caused the death each line.			-		st,	Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition resulting in death)	= 5 gar	oceviu	oms 6	f The si	well by	wel		2 years
	Medical aminer		resulting in death)	Due to	(or as a consequ	rence of):	•				•
		er	Sequentially list conditions,	b. ————	or as a consequ	ience of):					
petr	d ansit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,					
exec	an an rial-tr	Examin	resulting in death) Last	Due to	(or as a consequ	ence of):					
The law requires that the death certificate be executed	ohysicien and the burial-translt	dicai		d							
raffica	ng pt sest	Med	IF FEMALE:								
ath co	attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live b	tcome of pregnar pirth 2 DFetal	death 3	Ectopic pregnanc	<b>су</b>		23d. Date of de Month	livery Day Year
9 9	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐Unkno	nant at time of de own	eath 5	Other (specify) _				54,
Thet	ed by the detached		Part II. Other significant conditio	ns contributing to d	eath but not resu	itting in the ur	nderlving cause g	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
requires	5.8	d by				-	, ,		1 ☐ Yes	2 <b>2√</b> √0 3 □ P	robably 4 []Unknown
5 è	should	iete							24a. Was an	24b. Were at	utopsy findings available
The la	s certificete hes b irector, page 2 sl	Completed	*						autopsy perform	ed? prior to death?	completion of cause of
, i	tifice tor, p	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes 2 eath (Check only one		2 No
yaic	direce	To B	examiner? 1 □ Yes 2 <b>≥</b> No	Hospital: 1 ☐ I	Inpatient 2 🗆 8	ER/Outpatien	t 3 DOA	hor	Home 5 Residen		cify)
ding P	fter th		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. inju	iry at	28d. Describe hov	v injury occurred	
in in	or: A	cati	2 Accident investig	ation				Yes 2 No			
or At	ifier death. Director: After this certificate he in by the funeral director, page	Certification:	4 Homicide determi	ned 286. Place	of Injury - At houng, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R. State)	ural Route Number,
pital	eral I		29a, Certifier 1 Certifying	Physician: To the	heet of my know	vledge death	a coourred at the	ime, date and place	ce, and due to the cau	work) and manner as	atatad
o the Hospital or Attending Physicien:	within 24 hours effer death.  To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Medical E	xaminer: On the b	asis of examinati ner stated.	ion and/or inv	restigation, in my	opinion, death occ	curred at the time, dat	e and place, and due	to the cause(s)
To th	within To th comp	Me	29b. Signature and hills of certified	) 5	2055 C. D	ONEHOW	29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)
			Tan Chaule	elus DIR	ECTOR, ME	BOICIAL O	NC. DE	23675	1	April 1, 2	2008
V			30. Name and address of person v	who completed caus	e of death (Item	23a) (Type,	Print)	. 0	16	W 1/2	1207
			POSS C. DONELTO WER	10 Ji	mottopu	ous U	mer (en	er Di	ettemone,	MN <	1287
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4	2008	legistrar's Signat	Son	We .				

3. Time of Death

21756

2:00 P M

23<sup>Day</sup>

MARCH

2008

4c. County of Death

	Examir	er	4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, or Loc	ation of Death		4c. County	of Deat	n
		w	5332 HOLLOW TRE	E LANE			KEE	EDYSVILLE		WA	SHI	NGTON
És v	Funeral Director		5. Social Security Number 579-66-6075	. Sex 7. Ag 1⊠M 2□F	e (In yrs. la:	st birthday) Yrs.		Under 24 Hrs. 8. Date (Mon AUG.	th, Dav, Ye		9. Birtl	hplace (State or Foreign untry) HIO
	p		Usual Residence of Decedent									
	ylan how at		10a. State 10b. County		10c. City,	Town or Loca	ation					10d. Inside City Limits
	Ma-fs iffed	Director	MARYLAND WASHI	NGTON			KEEDYSV	ILLE				1 ☐ Yes 2 <b>X</b> No
	r 28	irec	10e. Street and Number				10f. Zip Code		10g.	Citizen of V	Vhat Co	untry?
	3a o	<u>~</u>	5332 HOLLOW TREE	LANE			2	21756		Ţ	J.S.	Δ .
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. W		nic Origin? (Specify Yes lexican, Puerto Rican, et	oi No-	14. Rac	e - Amei	rican Indian,
10	r Ite	Ē	1 ☐ Never Married 2 🏋 Married	Armed Forces? 1 ☐ Yes 2 🔀					c.)	Blac	k, White	, etc.
33	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		11	∐Yes 2⊠ No <i>Si</i>	pecify:		Specify	· WH	IITE
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleatith and Mental Hygiene. Items 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's	Education	I	16a. Decede	nt's Usual Occupation	1	16b	. Kind of Bu	ısiness/l	industry
7	in "in Medi	ple	(Specify only highest Elementary/Secondary (0-12)		54)	life. Do	nd of work done durin D NOT use retired)	ig most of working				
7	filed within Hygiene. ther than "	E	Elementary, elementary (el 12)	College (1-4or 5 <b>5+</b>			INSTRUCTOR	}		PUBLI	C S	CHOOL
P	il Hygie other	Be	17. Father's Name (First, Middle, La	st)			18.	Mother's Name (First, M	fiddle, Mai	den Surnam	10)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Menatic event	To B	GEORGE J. LAVEL	LE			l M	ARIE W. WHI	EELER			
	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship			19b. Mailing		Number or Rural Route		ity or Town,	State, 2	
Š	and 2 salth a n 27 Is		JOANNE M. LAVEL	LE/SPOUSE		5332	HOLLOW TRE	EE LANE, KEI	EDYSVI	ILE.	MARY	YLAND 2175
စ်	Health tem 27 other tra		20a. Method of Disposition	EL, CICCEL	20b. Pia		tion (Name of atory or other place)	Date		. Location -		
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once.		1 Burial 2 □ Cremation 3 4 □ Donation 3 □ Other (Spe					2/27/2009	,	ייייייייייייייייייייייייייייייייייייי	*****	C MADSZI ANID
≟	it. P		21. Sign ture of Fundral Service	/	FAL		CEMETERY Name and Address of	3/27/2008				E, MARYLAND
Ba	permit. Depart Import any Inj once,		NA VA		M.Dea		ST FUNERAL	HOME 7000		Natio		
			220 Party Enter the diseases of 2	mplications that causes	the death	Do not onto	the made of duing a				утаг	nd 21713
			23a. Party Enter the disease, or shock, or heart failure. List or	nly one cause on each li	ne.							Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition	a Card	101	nula	ronay A	trust			- 3	
-	/Medical Examiner		resulting in death)	Tue to (or as	a conseque	ence of):	6	,				
2.	Examine	,	Sequentially list conditions,	b. 14/11	orter	45W	Card	trust	Lin	D/3	Ru	<u></u>
	₽ #	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as	a conseque	ence of):						
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	am	that initiated events	c								
O,	an a		resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	icate be e physician s the buria	Physician/Medical		d								
99	riffice ng ph as ti	Med	IC CCLUI C	/== = W = = = V-						1		
Box	eath certif attending for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			ctopic pregnancy			23d. Dat	e of deli	ivery
	death e atte	icie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)			Mo	nth	Day Year
P.0	that the de ed by the a detached i	hys	9 Unknown	9□Unknown								
		>	Part II. Other significant condition			ting in the und	erlying cause given in	Part I. 23e	Did tobac	co use cont	ribute to	the cause of death?
ğ	quires n sigr ald be	q p	Markis	& obesit	7				1 🗌 Yes	2□ No	3 🗆 Pr	obably 4 <b>∐</b> Unknown
9	w require been sign	Completed	00		1			24a	. Was an	24h 1	Nere au	rtopsy findings available
æ	has ge 2						_		autopsy		orior to death?	completion of cause of
<u></u>	icate ha							1 🗆	Yes 2□		Yes	2□ No
₹	i <b>cian</b> : Tr certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	. Place of Death (Check	only one)			
7	Phys this al dir	P.	1 No 2 No	1 ☐ inpatie		R/Outpatient	3 DOA 1	1 ☐ Nursing Home 5 ☑				cify)
Division or Vital Records	ng l fter ner	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2	28b. Time of Injury	28c. Injury at Work?		cribe how i	injury occuri	ed	
Si Si	eath.	ati	2 ☐ Accident investigat	ho				2 No				
≅	er de irect	<u>₩</u>	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zoe. Flace of Rife	ury - At hom c. (Specify)	ne, farm, stree	et, factory, office	28f. Loca City	tion (Stree or Town, S	t and Numb tate)	er or Ru	ıral Route Number,
	talo rs aff alD	Ce										
	hour hour uner uner		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowl	ledge, death	occurred at the time, o	date and place, and due on, death occurred at the	to the caus	e(s) and ma	nner as	stated.
	To the Hospital or Attendl within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	one)	and manner st	ated.		on gotton, in my opinio	on, ocum occurred at the	amo, uale	and place,	and dde	to tric cause(s)
	To t To t	5	29b. Signature and title of certifier		_	_	29c. License nu	mber	29d.	Date signe	d (Monti	h, Day, Year)
			>dward b	V. Hitto I	II 16	$\sim$	1)0-0	1062	1	teril	8,	2008
			30. Name and address of person wh	no completed cause of d	leath (Item	3a) (Type, P	rint))	0/1/		- 11		717.12
4	14-12	<u>U</u> . 4	200 w.d. U 30. Name and address of person with Edw 22d w. D.	the TIN	19,011	Bicha	& terre	Be croyer	140 CV )	M		XITE

1. Decedent's Name (First, Middle, Last)

FOREST

LAVELLE

THOMAS

**Physician** 

Registrar APR 0 9 2008 32. Registrar's Signature

DHMH 17 Rev 1/2001

		1 _ For	State of Maryland	/ Depa	rtment o		Mental Hygi	ene 008	3 1286
		Registrar		Cer	unicate t	Dealli	2. Date of Death	g. No.	2 Time of Dooth
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  MINNIE MARY		DI			Month 04	Day Year	08 7:30 P
Exami	ner	4a. Facility Name (If not institution, give stre				n, or Location of Death	1	4c. County of De	
		GOLDEN LIVING GEN		4 5 5 db - d 1)		INSTER par If Under 24 Hrs.	10.5.4.45.4	CARRO	
Funeral Director		5. Social Security Number 6. Sex  212-20-0620  Usual Residence of Decedent	7. Age (In yrs. last	Yrs.	If Under 1 Ye Months Da	ys Hours Min.	Month, Day,	<sup>year)</sup> , 1924 Ba	inthplace (State or Fore Country) altimore, M
and		10a. State 10b. County	10c. City, 1	Town or Loc	cation				10d. Inside City Lim
e-fehc	ctor	MD Carroll	Hamp	stead					1 <b>X</b> ]Yes 2 □
or 28	Dire	10e. Street and Number			10f. Zip Coo		1	g. Citizen of What (	Country?
ath w	8	908 Century St.			21074			U.S.A.	
be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or Iteme 23a or 28e-f ehow event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2☒ Married  3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 Mo If Yes, Give Year or Dates:		Vas Decedent Yes, specify (	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
c * m	Completed by	15. Decedent's Educati (Specify only highest grade or	ion ompleted)	(Give i	lent's Usual Ockind of work do	ne during most of wor	king	6b. Kind of Busines	ss/Industry
filed within Hygiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		maker			Own Home	<u> </u>
should be filed withind Mental Hygiene. marked other than imatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Joseph DiPietro		1101110		18. Mother's Nar Frances	ne (First, Middle, M S Sortino		
s 1 and 2 should f Health and Men item 27 is marks other traumatic	F	19a. Informant's Name/Relationship (Type,  Joseph Lombardi –				eet and Number or Ru St., Ham		•	, Zip Code)
0 0		20a. Method of Disposition  11☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Plac	ce of Dispos	sition (Name o	ner cem. 4/0		Oc. Location - City of Baltimore	
permit. Pag Department Important: I any njury o		4 Donation 5 Other (Specify)  21. Signature of Fundar Super Licensee				dress of Facility Fr			& Chapel, 21157
Physician /Medical Examine per price and price private per price price price per per per per per per per per per pe	Examiner	shock, or hard failure. List only one of Immediate Charle (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer		nto age	Varen	lent her de	uni	Interval Between Onset and Death
the death certifica y the attending ph Iched for use as th	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	éath 3∏ th 5∏	Ectopic pregna Other (specify	)		23d. Date of d Month	delivery Day Year
w requires that been signed should be de	Ď	Part II. Other significant conditions contrib	outing to death but not resulting	ng in the un	derlying cause	given in Part I.	23e. Did toba		to the cause of death' Probably 4 □Unkno
The lay ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to	autopsy findings availa o completion of cause ? es 2 \( \text{No} \)
10 S	Be	25. Was case referred to medical examiner?	pital:			Other	th (Check only one		
	on: To	27. Manner of Death	I Inpatient 2EH	VOutpatient Bb. Time of Injury	28c. [	njury at Work?	ome 5 Resider 28d. Describe how	nce 6 □Other (Sp w injury occurred	pecify)
or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre		Yes 2 No	28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
• Hospitel 24 hours a • Funeral letely filled	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	an: To the best of my knowle : On the basis of examination and manner stated.	edge, death n and/or inv	occurred at th	e time, date and place ny opinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	401		29c. Lic	ense number	29	d. Date signed (Mo	nth, Dey, Year)
MSL		> Cloby W. M	ideleton "	my	D	52AA:	3	4/2/-	2008
<b>Y</b> 3		John W. Middle	eleted cause of death (Item 23	Vict	01	reet.M	Archeste	MD	21102
Sta Regist		31. Date filed (Month, Day, Year) $\Delta PR = 0.3 - 20$	32. Registrar's Signature	K	lane.	,		,	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gesa Maria Lamer	1	- For State Registrar	Sta	ate of	Maryla		epartme C <i>ertific</i> a		Health a Death	nd Me	ental Hy		Reg. No.	201	8	286
Physician Medical Examine	1	1. Decedent's Name Gesa		<sub>e,Last)</sub> Mari	.a		Lame:	rs				2. Date of Dea Month March 26	- Day	Year	3. Time o 1250	
Same Lat		4a. Facility Name (if Piscataway I		n, give st	reet and nui	mber)		41	b. City, Town, Clinton	or Locati	on of Death	,		County of Dea		
Funeral Director		5. Social Security No. 213—88—38	umber 378	6. Sex	2 X F	7. Age (In y 37	rs. last birth	day) Yrs.	If Under 1 Ye		Inder 24Hrs.	_		DD/YYYY) 9. B Fore	Birthplace (St eign Was Country)	shington DC
v any			Decedent 10b. County		25	10c.	City, Town o		on			۲.				e City Limits
the Maryland a or 28a-f showified at once.		Idaho  10e. Street and Num					Cald	wett	10f. Zip Code		÷		10g. Citiz	en of What Co	ountry?	s Z No
with the N	= L	3120 Pono		1:	2. Was Dec		in U.S.			lispanic		ecify Yes or N	0-	14. Race - Amo White, etc.	JSA erican Indian	, Black,
after death	by run	Never Marrie     Widowed	4	orced or	Armed Fo Yes Yes, Give Yea Dates:	2 <u>X X</u> I		1	es, specify Cub	lo <i>sp</i> e	cify:			Specify: Wh	nite	
36 in 72 hours han "natur lical Exam	ompleted	15. Decedent's Ed		T	College (1		<u> </u>		's Usual Occup est of working li .an				116b. K	ind of Busines Medi		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the M dica	He Com	17. Father's Name (	First, Middle,	Last) B.	Lan	ers				18. <b>M</b> o		(First, Middle,	Maiden :	Surname) Kohte		
MD 212 td 2 should be allth and Ment m 27 is marlt ann artice even		19a. Informant's Nam Yermo Lam										Rural Route Nu Park, M		ty or Town, Sta nd 207		)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatte event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 XXBurial 2 4 Donation 5	Cremation		Removal fro	om State	cremato	ry or oth	tion (Name of or er place) Ch. Cemet			Date 7/2008		ocation - City inton, M		
Baltin permit. Departm Importa	-	21. Signature of Fur	neral Service	Licensed	win	4		61		Hi11	Road C	xon Hill	, Mar		Home P 20745	.A.
Physician /Medical ==xaminer		23a. Part I. Enter the failure. List onli	y one cause	on each	itions that c line. Ultiple Inji		eath. Do no	t enter th	e mode of dyir	ig, such	as cardiac o	r respiratory a	rrest, sho	ck, or heart		mate Interval en Onset and Death
Sr.	_	or condition resulting	nditions,	b	e to (or as a										_	<del></del>
		if any, leading to im cause. Enter Under (Disease or injury tr events resulting in o	rlying Cause nat initiated	ė	e to (or as a										-	
b0, te be executed ysician and burial - transit	edical E	UNPENDED	· · · · · - <del>-</del>	d	MENDED							<del></del>			-	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  Ye the Funeral Director: After this certificate has been signed by the attending physicopropeledy find in by the funeral director, page 2 should be detached for use as the but the completely find in by the funeral director, page 2 should be detached for use as the but the find the detached for the page 2 should be deaded for use as the but the find the deaded for the page 2 should be deaded for use as the but the find	ΣΙ	IF FEMALE: 23b. Was decedent past 12 months	?	ne	23c. If yes,  1 Live b 4 Pregr	oirth nant at time	2		al death ner (Specify)	3 <u>E</u>	etopic pregna	ancy	230	d. Date of deliving Month	ery Day	Year
P.O. Es that the dest that the dest that the described by the detached	2	Part II. Other signif	ficant condi	ions co	ontributing to	o death but	not resulting	in the u	nderlying caus	e given i	in Part I.			use contribute No 3 P		
of Vital Records,  ng Physician: The law require  ufter this certificate has been si meral director, page 2 should b	Completed											рег	s an opsy formed?	prior t death	o completion?	ings available of cause of 2 No
Vital F	8	25. Was case referr examiner?	,		pital:	Inpatient	2 ER/O	ıtpatient		Othe	eath (Check	only one)	Reside	ence 6 🗸 Ot	her: Scene	
ion of Virtending Physicath.  or: After this the funeral dir	ion: To	27. Manner of Death  1 Natural	No h 5 Pen	ding	28a. Date	<u> </u>		Time of Ir	njury 28c. I	njury at \	Work? 2 ✓ No	28d. Describ Driver auto				
Division spital or Attendir hours after death. neral Director: △ / filled in by the fu	Certification:	2 ✓ Accident 3 Suicide 4 Homicide	6 Cou	stigation ld not be rmined		e of Injury -		rm, stree	et, factory, offic	e buildin	ig, etc.	28f. Location or Town, Piscataway		and Number or Clinton, MD	Rural Route	Number, City
Divi	Medical C	29a. Certifier	Certifying P Medical Exa	miner:0	: To the bes n the basis nd manner s	of examinat	owledge, dea tion and/or in	ith occur ivestigati	red at the time ion, in my opin	date an	id place, and th occurred a	due to the ca at the time, dat	use(s) an te and pla	id manner as s ace, and due to	tated. the cause(s	)
10	¥e	29b. Signature and	title of certific		Q.	() L			29c. Lice O.	nse nun				Date signed (in the case) Date signed (in the case)		(ear)
Je.		30. Name and addre					(Item 23a) cal Exam	iner	111 Penn	Street	, Baltimo	re, MD 212	01			
Sta Registra	te ar	APR 0 7	h, Day Year) 2008	ke	32. Re	egistrar's Si	gnature									
DHMH 17 Rev 1/200	_		-			1	OR	IGINA	 L				OCME			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Physician Month April 2, 12:05 William A. Lorenz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7101 Bayfront Drive, Apt. Anne Arundel Annapolis 6. Sex 1 M M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/13/1927 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 80 Director 279-20-4027 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f shiner must be notified 1 ☐Yes 2 ☐No Directo Annapolis Marvland| Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7101 Bayfront Drive, Apt. 512 USA 21403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Forces:
1 TyYes 2 □ No
If Yes, Give
Year or Dates: 1945-47 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ∏ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Transportation Manager Transportation is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivy Hecker Aaron George Lorenz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce C. Lorenz/ Wife r portant: If item 27 7101 Bayfront Dr., Apt. 512, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 4-7-08 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edg
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line. 2973 Solomons Island Rd. Edgewater, MD 21037 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ective Swallow Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident Injury 5 Pending investigation 1 □ Yes 2 □ No Funeral Director: stely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 h To the Fu one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Dav. Year) State APR 0 4 2008 Registrar

Physician

1.	For	Plea	a <b>se Type o</b> l State				<b>delible Ink</b> artment of h			-		_	ible.		
Special Security Number   Province of consistence of the period cons	1 - For State Registrar				.,							01	008		2868
45. Class y House			. ,							Month	D	ay	Year	3. Time	e of Death
Case   House   Montgomery   Hospice   Sould Beauty Name   Flesh Montgomery   Sould Beauty Name   Flesh Montgomery   Sould Beauty Name   Flesh Montgomery   Sould Beauty Name   Flesh Name   Sould Beauty Name   Flesh Name   Sould Beauty Name   Flesh Name   Sould Nam							# 01 F			Apri1					LO P M
Social Security Number   Size   April   Face   Ap						_	_		of Death		4				
Top   Description   Descript									r 24 Hrs.	8. Date of B	irth				te or Foreian
Usual Recipione of Decoder   Usual Country   Usual Decoder	579-09-5	619	1 <b>∑</b> M 2□F		90	Yrs.	Months Days	Hours	Min.				Co	untry)	
MD   Montgomery   Bethesda   10, 2p code	Usual Residence of	Decedent								Dec.	7 ـ ـ ـ ـ ـ ـ	17	Wasii		
100, 26 codes   200, 26 code					10c. City,										
11. Martial Status   12. Was Depoched Ever in U.S.   13. Was			gomery												es 2 X 140
11. Marital Status 1   12. Wise Depocher For In U.S.   13. Was			Road					0817						•	
1   Secondary   1   Secondar				cedent Ev	ver in U.S.	13 1			rigin? (Sn	ecify Ves or N					
16. Decedent's Localization (Specify 201) pileptic guides completed   1940   16. Decedent's Localization (Specify 201) pileptic guides completed   17. Fether's Name (Frest, Middle, Last)		ied 2∐ Mar	Armed	Forces?		i   10.	If Yes, specify Cub	an, Mexic	an, Puerto	Rican, etc.)	10-				1
Comment Name (First, Modife, Last)   College (1-4cr 5+)   Architect   Dept. of Navy	3 X Widowed	4 Divorced	If Yes, 0 Year or	Give Dates:	1946		1 ☐ Yes 2 💢 No	Specify	y:			Speci	ify: W	hite	
T. Father's Name (Fist, Middle, Last)   Teresa Norris	(Spec	15. Deceder	nt's Education	<del>-/</del> )		16a. Dece	dent's Usual Occup	ation	et of work	rina	16b.	Kind of I	Business/I	ndustry	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Master Sumane)   19. Mother's			College	<u> </u>	)	lite. I	DO NOT use retire Architect	i)		wig	De	ept.	of N	lavy	
198. Informart's Name-Relationship (Type. Print)   199. Mailing Address (Street and Number of Nural House Number, City or Town, State, 2ip Code)	17. Father's Name (	First, Middle,						18. Moth	ner's Nam	e (First, Middl	e, Maide	ən Surna	me)		
Maria Law/ Daughter   20a. Method of Disposition   20b. Place of Disposition   20b.	James	Desmon	d Law					Т	eresa	a Norri	.s				
20. Place of Disposition (Name of Complete)   20. Place of Disposi	19a. Informant's Na	ame/Relations	ship (Type. Print)			19b. Mailir	ng Address (Street	and Numi	ber or Rui	ral Route Num	ber, City	or Town	n, State, Z	ip Code)	
Cate of Heaven   2008   Silver Spring, MD	Maria La	w/ Dau	ghter						ad, I	3e <b>t</b> hesd	a, l	MD 2	0817		
4 Signature of Functions (Specify)  233. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory, with 2087.  234. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  235. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  236. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  237. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  238. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  239. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  239. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as audides or respiratory arrest.  230. Date of delivery.  231. Date of delivery.  232. If yes, outcome pf pregnancy of the program of the progr			3 ☐Removal from	m State				ce)			20c.	Location	- City or	Fown, State	,
DeVol Funeral Home, 10 East Deer Park Drive, Caithersburg, Mn 20877					Gate			i	2008		Si	lver	Spri	ng, M	ID
23a, Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate interval between forces and part of the	21. Signature of Fu	neral Service	Licenson					eral	Home	e, 10 E	ast	Dee	r Par	k Dri	Lve,
Interestation cause (Final disease or condition resulting in death)   Last	23a. Part1. Enter the	ne disease, or	r complications that	t caused the	he death.	Do not ent	er the mode of dyi					MIL Z	1811	Approxir	nate Potygon
Due to (or as a consequence of):  Cerebral Vascular Accident  Due to (or as a consequence of):  Cause (Disease or injury) that inhiated events resulting in death) Last    IFFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   ve birth 2   retail death   2   retail death   3   Ectopic pregnancy   1   ve birth 2   retail death   3   Ectopic pregnancy   1   ve birth 2   retail death   5   Other (specify)   Month   Day   Year      Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23c. Was a reserved to medical examiner?   25c. Was case reterred to medical examiner?   25c. Was case	Immediate Cause (	Final	tonly one cause of											Onset a	nd Death
Due to (or as a consequence of):   TFEMALE:   23d. Date of delivery   23d. D		.,	a. Due to				-								
Comparison   Com	Sequentially list con	nditions	b				Vascular	Acci	dent						
Pert   I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   1   2   2   No 3   Probably 4 (Nonknown   24a. Was an autopsy performed)   1   1   Notes   2   No 3   Probably 4 (Nonknown   24a. Was an autopsy performed)   1   1   Notes   2   No 3   Probably 4 (Nonknown   24a. Was an autopsy performed)   1   Notes   2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 3   Probably 4 (Nonknown   24a. Was an autopsy   1   Yes 2   No 4   Yes 2	if any, leading to im cause. Enter Unde	mediate rlying	Due to	o (or as a	conseque	nce of):									
IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   yes   2   No   9   Unknown   23c. If yes, outcome pf pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   yes   2   No   3   Probably   4   X Unknown   24a. Was an autopsy performed?   1   yes   2   No   3   Probably   4   X Unknown   24b. Were autopsy findings available examiner?   1   yes   2   Xo   No   1   yes   2   Xo   2   xo   yes   2   Xo   1   yes   2   Xo	that initiated events resulting in death) L	.ast	c	n (or as a	conseque	nce of):					_				
23b. Was decedent pregnant in the past 12 months?   1				o (or do d	conocque										
23b. Was decedent pregnant in the past 12 months?   1			d												
in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death? 1   Yes 2   No 3   Probably 4   X Unknown  24a. Was an autopsy performed? 1   Yes 2   No   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other:   All Presidence   All Presid		pregnant	23c. If yes, o	utcome pt	f pregnanc	су	-					23d. D	ate of deli	verv	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Munknown	in the past 12	months?	4□Pre	gnant at ti				/						-	Year
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Noticide 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 3 Suicide 4 Homicide 28. Date of Injury 28. Date of Injury 3 Suicide 4 Homicide 28. Date of Injury 28. Date of Injury 28. Date of Injury 3 Suicide 4 Homicide 28. Date of Injury 28. Date of Injury 28. Date of Injury at Work? 1 Yes 2 No 28. Describe how injury occurred  28. Describe how injury occurred  28. Location (Street and Number or Rural Route Number, City or Town, State)  29. Certifier (Check only one)  29. Signature and title of certifier  29. License number  D0064615  April 2, 2008	9 ☐ Unknown		9LJUnk	nown											
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  1 Yes 2 No  27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA  28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 29c. License number 28d. Describe how injury occurred 28d. Describe how i	Part II. Other signif	icant conditi	ons contributing to	death but	not resulti	ing in the ur	nderlying cause giv	en in Part	I.	23e. Did	tobacco	use cor	ntribute to	the cause	of death?
25. Was case referred to medical examiner?    To be solved to the control of the										1	Yes	2 No	3 ☐ Pro	obably 4	<b>X</b> Unknown
25. Was case referred to medical examiner?    1												24b	. Were au	topsy findin	gs available
Continue										peri 1∐ Yes	formed? 2 X N	10	death?		or cause of
27. Manner of Death   Natural   2   EH/Outpatient   3   DOA   4   Nursing Home   5   Residence   6   Other (Specify)   Hospice		red to medica					1		e of Deat	h <i>(Check only</i>	one)				
1 Natural 2   Accident 3   Suicide 4   Homicide   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   D0064615   April 2, 2008			1 1			·	1 3 DOX	4 LI IV						ify) Hos	pice
Suicide 4 Homicide  28e. Place of injury - At home, farm, street, factory, office  29a. Certifier (Check only one)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  28g. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29d. Date signed (Month, Day, Year)	1 XNatural	5 ☐ Pendin	ng (Mo				Wor			28d. Describe	how inj	ury occu	rred		
29a. Certifier (Check only one)  29b. Signature and title of certifier D0064615  29c. License number D0064615  City or Town, State)  29a. Certifier (Check only one)  29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier D0064615  April 2, 2008	3 ☐ Suicide	6 Could	not be	ce of injury	y - At hom	e, farm, str		100 2		28f. Location	(Street a	and Num	ber or Ru	ral Route N	lumber
(Check only one)  2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  April 2, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 Homicide	detern	buil	ding, etc.	(Specify)					City or To	wn, Sta	ite)	207 07 714	rar riodic ri	idilibei,
D0064615 April 2, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(Check only	1 ☐ Certifyir 2 ☐ Medical	Examiner: On the	basis of e	examinatio	edge, death on and/or in	occurred at the tivestigation, in my	ne, date a	and place, eath occur	and due to the red at the time	e cause e, date a	(s) and m	nanner as , and due	stated. to the caus	se(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29b. Signature and	title of certifie	Pľ.				29c. Licens	e number			29d. D	ate sign	ed (Month	, Day, Yea	r)
	1 2	ne	Whe	2			D00	6461	5		Aŗ	ril	2, 2	800	
, , , , , , , , , , , , , , , , , , ,		-			,	,	· ·	, Su	ite 1	.00 . Ro	ckvi	111e	MD	20850	

State Registrar

DHMH 17 Rev 1/2001

\*31. Date filed (Month, Day, Year) APR 0 4 2008

32 Registrar's Signature

			1- State of Marylar State of Marylar		artment of He rtificate of D		ental Hygie Reg.		12869
	Physici	_	1. Decedent's Name (First, Middle, Last)  Gerard J. Lonergan				2. Date of Death Month 4/2/2	Day Year	3. Time of Death 1:10pm
	/Medio		4a. Facility Name (If not institution, give street and number)  Mandrin Hospice House		4b. City, Town, or L	ocation of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 212-42-7052  6. Sex 1 ★ M 2 □ F  6.				8. Date of Birth (Month, Day, Ye 9/30/194	9. Birth	place (State or Foreign
	Maryland f show ied at	or	Usual Residence of Decedent	ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XNo
	with the la or 28a-	Direct	10e. Street and Number 130 Hearne Rd. Apt. 513		10f. Zip Code	1401	10g.	Citizen of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1		Was Decedent of Hisp f Yes, specify Cuban		cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	within 72 ho iene. • than "natur the Medical!	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life. i	dent's Usual Occupati kind of work done du DO NOT use retired)		g	. Kind of Business/In	-
land 2	uld be filed Mental Hyg Irked other Itic event, 1	To Be C	17. Father's Name (First, Middle, Last)  James Lonergan	J	1	8. Mother's Name Mary Tarl	(First, Middle, Maid		
	and 2 sho ealth and I n 27 is ma ier trauma		19a Informant's Name/Relationship (Type Print) Ellen Hadfield Sister		ng Address <i>(Street an</i> Conduit St		Route Number, Ci	ity or Town, State, Zij 21401	Code)
Baltimore,	. Pages 1 Iment of Ha tant: If iten jury or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei • Mary	sition (Name of natory or other place) s Cemeter	y 4/7/20	008 An	napolis,	MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	12	Ridgely .	Ave. Anr	apolis,		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consec	2	er the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
1	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C  Due to (or as a consected death)	uence of):					
P.O. Box 68	ath certific ttending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitution of the pregnant at time	al death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause given	in Part I.	23e. Did tobacc	co use contribute to t	he cause of death? pably 4 □Unknown
Vital Records,	sician: The law certificate has b irector, page 2 sl	Completed	OF Western day and the				24a. Was an autopsy performed 1∐ Yes 2 €	prior to co death?	psy findings available mpletion of cause of 2 No
Division or Vit	ding Phy n. After this funeral d	Certification: To Be	27. Manner of Death Natural 5 Pending (Month, Day Year) 1 Accident Investigation	ER/Outpatien 28b. Time of Injury	t 3 DOA Other:	at 2	le 5 ☐ Residence 8d. Describe how in	e 6 Bother (Special njury occurred	
Div	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier  29a. Certifier  Charles all the determined Charles and the building, etc. (Specifier Charles all the building). To the best of my known that the building control to the best of my known the building control to the best of my known that the building control to the best of my known the building control to the best of my known that the building control to the best of my known that the building control to the best of my known that the building control to the best of my known that the building control to the building				City or Town, S.	tate)	
•	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.  29b. Signature and the of certifier	won and/or in	29c. License r	number	29d.	Date signed (Month,	tated. o the cause(s)  Day, Year)  ZWS  YMD  2 1 YeJ
<u>(</u>	eCH		30. Name and address of person who completed cause of death (Iten STBN2) UNTHINS	700	Print) BESY6A	OTIL RU	BNI	VAPULIS	Mosilad
	Sta Registr	ar	31. Date filed (Month, APR 0 3 2008	ture A	frank				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	partment of Health and Mertificate of Death	nental Hygier	200	12870
Physic /Med		Decedent's Name (First, Middle, Last)     Fiorenzo Losco		2. Date of Death Month 3/30/	2008 Year	3. Time of Death 6:10am M
Exam	iner	4a. Facility Name (If not institution, give street and number)  Spa Creek Center  5. Social Security Number 6. Sex 7, Age (In yrs. last birthd)	4b. City, Town, or Location of Death Annapolis  A) If Under 1 Year   If Under 24 Hrs.		Anne Aru	
Funera Director		5. Social Security Number 6. Sex 123 M 2 F 7. Age (In yrs. last birthde 86 Yrs	Months Days Hours Min	8. Date of Birth	Massa	lace (State or Foreign try) Chusetts
te Marylan 8a-f show	ctor	10a. State 10b. County 10c. City, Town or Anna Arundel Annap			1	0d. Inside City Limits 1 ☐ Yes 2€00No
ath with the 23a or 2	Funeral Director	7 Somerset Ct.	10f. Zip Code 21403	10g. (	Citizen of What Coun USA	
ifild XIXID-UUSO  be filed within 72 hours after death with the Maryland tial Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No 44 - 67  If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 X No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of Specify:	
LIZID-UUJO d within 72 hours af giene. r than "natural", or	Completed	(Specify only highest grade completed) (Gillie Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work be DO NOT use retired) Col	ing	Kind of Business/Ind	,
_ 0 = 0 2	Q.	17. Father's Name (First, Middle, Last) Raphael Losco	18. Mother's Name	e (First, Middle, Maid se Renaldi		711 III.y
Mary of 2 shoul of 2 shoul of 2 shoul of 2 shoul	F	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Run			Code)
nore, ages 1 ar ent of Hea tt: If Item 3		1 M Danial 2 Dolemation 3 Differnoval from State	rematory or other place)		Location - City or To	
Dallimore, INarylat permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic evence.			n National Cem 5/2 22. Name and Address of Facility Har 12 Ridgely Ave. A	desty Fund	-	
Physician /Medical Examiner	ı	Due to (or as a consequence of):	enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rial director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause. Plant Underlyin Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c				
the death certily the attending ched for use a	Physician/Med		B⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	T .	use contribute to the	e cause of death? ably 4 ∐Unknown
in: The law recilicate has bee	e Completed	25. Was case referred to medical		24a. Was an autopsy performed?	prior to con death?	asy findings available opletion of cause of 2 ☐ No
ing ing	To B	examiner?  1  Yes 2	of 28c. Injury at	me 5 ☐ Residence 28d. Describe how inj		)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, Sta	ite)	
the Hosp thin 24 hot the Fune	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	red at the time, date a	nd place, and due to	the cause(s)
To To	-	29b. Signatura and title of certifier	29c. License number D31d 76	29d. D	Pate signed (Month, E	yay, Year)
HOH	1	30. Name and address of person who completed cause of death (Ijem 23a) (Type 200)	). Been Bkins	chel	~ wo 3	21619
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 3 2008  32. Registrar's Signature	Sperke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaai Physician 2008 8:40 A M April Durnice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury

5. Social Security Number Rehab + Nursing Ctr.

6. Sex, 7. Age (Intyrs. last birthday) Wicomico isbu Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2□ F 9 419-48-250 Director 6 Jan. 17, 1939 Alabama Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No **Funeral Director** MDDorchester Rhodesdale 10g. Citizen of What Country? 10e Street and Number ortant: If Item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be r US, 2165 Maiden torest 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 2 No /96/ Pages 1 and 2 should be filed within 72 hours after 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ 3 Widowed 4 Divorced 196.3 Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COMMunication-technician GOV, Transportation 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Lewi McCallester ပ Hamp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: if Item 27 is any Injury or other trau Walker Lewis 4758Maiden Forest Road Rhodesdale MD, 21659 Vatice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/08 4 □ Donation 5 □ Other (Specify) Cemetery HUYlOCK, MD. Veterans 22. Name and Address of Facility HENRY FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Hewry Funeral Home, P. A.

510 Washington St. Cambridge,

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line. MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -0 2100 001 /Medical ue to (or as a consequence of): Examiner ear. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. physician Physician/Medical the use as t attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 JA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 3□ DOA Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and mannerstated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins c Ave. William H. M

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrer	State of Ma	ryland /		irtment of F tificate of i				giene Reg. No	.000	12872
	Physici /Medic		Decedent's Name (First, Middle, Las  KARL	H. LOSS	ow,	JR.				2. Date of De Month April	ath Day	2008 Year	3. Time of Death 8:10 A M
	Examin		4a. Facility Name (If not institution, give 27493 Coulbourne		i i		4b. City, Town, or Marion					. County of Deatl Somerset	
	Funeral Director		5. Social Security Number 6. Se 135–52–5222	X 7. Age	(In yrs. last b	irthday) Yrs.	tf Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bird (Month, Da June 6,	v. Year)	9. Birtl Co. New	nplace (State or Foreign untry) Jersey
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	e Mary la-f sh	ctor	Maryland Somers	et			Marion	Sta	tion				1 ☐ Yes 2/2/10
	th with the	al Director	10e. Street and Number 27493 Coulbourne	Creek Roa	ıd		10f. Zip Code	2183	38		10g. Cit	izen of What Co USA	untry?
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show after Experiment be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 AN If Yes, Give Year or Dates:	iver in U.S.		Vas Decedent of H i Yes, specify Cuba	lispanic O an, Mexica Specify		ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Wh	
0-6121	d within 72 ho piene. r than "natur tre Medical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) Cottege (1-4or 5-		a. Deced (Give life. L	lent's Usual Occup kind of work done of DO NOT use retired Landsca	during mo d)	ost of work	ng		ind of Business/	•
and 2	be filed ital Hyg id other event,	Be	12 17. Father's Name (First, Middle, Last) Karl H. Lossow				Darrasea	18. Moth		<i>(First, Middl</i> e, rdung			119
5	s 1 and 2 should f Health and Men item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (T	ype, Print)	19	b. Mailin	g Address (Street				er, City o	or Town, State, Z	<sup>(ip Code)</sup> 21838
e, Mai	nd 2 alth a 27 Is		Karl H. Lossow (F	ather)		2749	3 Coulbo	urne	Cree	k Road	<b>–</b> Ма	arion St	ation, MD
ore	Pages 1 a nent of Hes int: If item iry or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 1	Removal from State			sition (Name of natory or other place			ate		ocation - City or	
altimor	permit. Pages Department of Important: If i any Injury or o		* 4 □ Donation 5 □ Other (Specify 21. Signature of Fu		Salis	22	Cremato:	ss of Faci	4/4/	-		isbury,	Maryland
מ	Per III		Robert H. Br				adshaw & Mai					MD 218]	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finat disease or condition	lications that caused to the cause on each line	the death. Do		er the mode of dying					,	Approximate Intervat Between Onset and Death
	/Medical Examiner	er	resulting in death)  Sequentially list conditions,	Due to (or as a	Fe Fis	of):	C						years
	and I-transit	Examine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
08/00	ficate be executed physician and ts the burial-transit	edical E		d									
O. Box 6	certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 ☐ Fetal deat		Ectopic pregnancy Other (specify)	,				23d. Date of deli Month	very Day Year
ecords, P.	The law requires that the death to has been signed by the atter vage 2 should be detached for u	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the ur	derlying cause giv	en in Part	1.	23e. Did to		/	the cause of death?
L Reco	10	Completed										prior to death?	topsy findings available comptetion of cause of
VITAI	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			2 DOA Othe			(Check only o			
io uc	Ph)	ion: To	27. Manner of Death  1 Natural 5 Pending	1 ∐Inpatien 28a. Date of Injury (Month, Day	nt 2 ☐ ER/O / /ear) 28b.	Time of Injury	28c. Injun	4 🗆 🛚 🔻		ne 5 NResid 28d. Describe l		6 □Other (Spec ry occurred	ify)
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injui		arm, stre		103 4		28t. Location (\$ City or Tox	Street an vn, State	nd Number or Ru a)	ral Route Number,
	e Hospita 24 hours Funeral letely filled	edical C	29a. Certifier (Check only one)	sician: To the best of iner: On the basis of and manner stat	examination a	je, death nd/or inv	occurred at the timestigation, in my of	ne, date a pinion, de	and place, a	and due to the ed at the time,	cause(s) date and	) and manner as d place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29h Signature and title of certifier	/1			29c. License	e number			29d. Da	te signed (Month	n, Day, Year)
			1000 17	47			D 00!	5993]	l		(	1/3/18	
	ŁΒ		30. Name and address of person who c Charles Hofmann, I	M.D 304	34 Mou	nt V	ernon Rd	Pr	cince	ss Anne	, MI	21853	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2	32. Registrat	r's Signature	No.	berth						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04/02/2008 Mary Elizabeth Mills 8:41  $\mathbf{P}^{\mathsf{M}}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Year) 1 M 2 X 215-07-7502 91 Director 10/14/1916 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 ☐ No Director Md. Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1542 Emory Church Road 21155 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ white Specify: 3 ₩ Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) credit manager food industry 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Keyes Kathryn Elizabeth Lindner ဂ permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Nelson, granddaughter 1542 Emory Church Road, Upperco, Md. 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 4/5/08 Hampstead, Md. 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Tanda Eline Funeral Home semmer 934 S. Main Street, Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EFT CCIPINAL cerebroussculou accident **Physician** lweek /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and -tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? res 2/2 No certificate or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) DOUP HOUSE 2 No Certification: To 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LUN 31660 04/03/2008 w

WJL 3

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AVENUE CHESTAW STER MAKYLAR & 21157

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ManshallA. Levine 6569 Nonth Charles St. Suite 205

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day April 2, 2008 Medical Examiner 1552 hrs Guillermo Enrique Medina 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Arlington Director Months Days Hours 231-65-7243 1 X M 9/4/1992 15 Usual Residence of Decedent 'n 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 X No MD Prince George's New Carrollton hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 6506 Lamont Place 20784 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. 1 X Never Married 2 Married Armed Forces' White etc. Yes 2 X No Widowed If Yes, Give Yee Divorced 1X Yes 2 No specify:Salvadoran Specify: Hispanic ş 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical injury or other traumatic avent, the Medical MD 21215-0036 High School Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gilber E. Medina Anna M. Marquez 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilber E. Medina - Father 6506 Lamont Place, New Carrollton, MD 20784 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Metropolitan Crematorv 4/8/08 Alexandria, VA Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Danner Gasch's Funeral Home, P.A.Hyattsville, MD 20781 23a. Part I. Enter the disease, or complications that caused the death. Do not the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Stab Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine couse. Enter Underlying Cous-(Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Dav Year past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page ✔ Yes 2 certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other DOA this Nursing Home 5 Residence 6 Other: No 1 V Yes 28a. Date of Injury (Month, Day Year Apr 2, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed 1 Natural 1444 hrs 1 Yes 2 ✔ No neral Director: filled in by the f Pending hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 6001 Goodluck Road, Riverdale, MD determined (Specify) Local Street the Funeral 4 V Homicide 29a. Certifier 24 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. April 3, 2008 30. The and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Ye 32. Registrar's Signa State

Registrar DRIVIER 17 Rev 1/2001

**OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month D. Messinger 16, /Medical March 2008 5:08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2 🖾 F Days Hours Min. 150-26-7986 83 April 14, 1924 United Kingdom Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Carvel Circle Funeral 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spokes ၉ Henry Kathleen Grundy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. Messinger Jr / Spouse Carvel Circle, Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3 ☐Removal from State 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 4/4/2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signatore of Fune al Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1 2No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 XER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident

as the burial-transit (1) essinger, Joan 3/14/08 1708 Division or Vital Records, P.O. Box 68760. attending physician for use as the buria ed by the a page 2 should be has certificate funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the i

Certification:

Director

28a-f show

ö

"natural", or items 23a

er than "natur, the Medical F

27 Is marked of traumatic even

Item 27 I

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once.

**Physician** 

/Medical

Examiner

be notified at

must

Maryland

Pages 1 and 2 should be filed within 72 hours after death

Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

6 Could not be determined 3 ☐ Suicide 4 Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney steed. 29b. Signature and title of certifier

29c. License number

D42181

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

March 18, 2008

30. Name and address of person wh completed cause of death (Lem 23a) (Type, Print)

Enrique Daza Rácines, 6420 Rockledge Drive #2500, Bethesda, MD 20817 M.D. 31. Date filed (Month, Day, Year)

State Registrar

APR 042008



To the Hospital within 24 hours at To the Funeral D

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended#23a perMD FCHD, KS Certificate of Death#24a,b 19a Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Albert Madara Physician 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner of Mary Jane Medical Center Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Country) PA Days 1 M 2 □ F 211-40-0061 58 1949 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 TXNo MD Frederick Director Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4530 Willow Tree Dr. 21769 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) salesman steel co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold A. Madara Daunis Fagley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship\_(Type. Print) 4530 Willow Tree Dr., Middletown, MD 21769 Karen madara (Wife) Pages 1 and 2 item 27 i Karen Madara 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any Injury or ot 2 X Cremation 3 □ Removal from State on 5 □ Other Specify) 1 Buria Smithsburg Crematory4/7/2008Smithsburg, MD 4 Don ion Donald B. Thompson Funeral Home Signature P. O. Box 18, Middletown, MD 21769 ter the disease, or complica heart failure. List only one Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★★ 0 24a. Was an certificate has autopsy Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P22137 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene St, Baltimore, MD Farrell Pac 32. Registar's Signature Date filed (Month, Day, Year) 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Page Not Found

DHMH 17 Rev 1/2001

State

Registra

MEMORIAL HOSPITAL, COMBERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

MARK SAGIN, M.D.

APR 2 1

31. Date filed (Month, Day, Year)

## /Medical Examiner **Funeral** Director a or 28a-f show be notified at Director Merric ral", or items 23a ( Examiner must b Completed by Funeral 'natural', or Baltimore, Maryland 21215-0036 the Medical Pages 1 and 2 should be filed within 72 in neutron the self and Mental Hygiene. eanette permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the Be **Physician** /Medical Examiner

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Jeanette Elizabeth Merrick 2008 11:20 AM 4 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rehab & Nursing Ctr. Salisbur lisbury Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) Days Hours Months 1 □ M 2 🕅 F 220-28-0102 10-25-1920 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X□Yes 2□No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 200 Civic Avenue 21804 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Store Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Turpin Carrie Hearn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Anderson – daughter 6830 Hayley Ridge Way, Unit H, Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Allen Cemetery 4-7-2008 Allen, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses wills 705 E. Main Street, Salisbury, Maryland 21804 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Zeuznoz Due to (or as a consequence of): he cre Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (r as a consequence of) burial-tran Due to (or as a consequence of) Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2 9 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Civic Ave. Jilliam H. Robins MID APR 0 7 31. Date filed (Mont) gistrar's Signature State Registrar

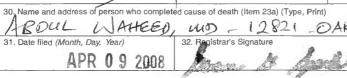
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				Ctoto	f Manulane		and an and a	of LI	aalah	and A	10040111			
			For State Registrar		of Maryland		rtificate				·	Reg. No.	0000	3 12881
	Physici /Medio		1. Decedent's Name (First, Middle Catherine El	lizabeth							2. Date of D. Month	Day 4	200	8 T:54 AM
	Examir	er	4a. Facility Name (If not institution				4b. City, To			of Death			County of De	on County
f	Funeral Director		Washington Co 5. Social Security Number 026-24-7140	6. Sex 1□M 24 F	7. Age (In yrs. la 74	a <i>st birthday)</i> Yrs.	Hage If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D July-7	ent les	100	irthplace (State or Foreign Country) MA
į.	ъ		Usual Residence of Decedent								July-/	, 190.	5 1508	
	e Marylar a-f show tifled at	ctor	Maryland Washin			, Town or Lo erstowi								10d. Inside City Limits 1 □ Yes 2 No
	with the	Dire	10e. Street and Number				10f. Zip C					-	izen of What (	Country?
	eath v	eral	11520 Selema Dr		edent Ever in U.S	3 13 1	2174		snanic ∩r	igin? (Sp	ocify Vac or N			nerican Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 12. Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed Fo	orces?		f Yes, specify				ecify Yes or N Rican, etc.)		Black, Wh Specify: Wh	ite, etc.
215-0036	72 ho "natur dical	eted	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced	dent's Usual ( kind of work DO NOT use	Occupa done a	ation furing mos	st of work	ing	16b. Ki	ind of Busines	s/Industry
2121	should be filed within 7. and Mental Hygiene. s marked other than "n umatic event, the Medi	dmo	Elementary/Secondary (0-12)	College (			ng Ass					Hos	pital	
b	other other	Č.	17. Father's Name (First, Middle	, Last)		True Du				er's Name	e (First, Middle			
ylar	Menta Menta arked atic ev	To E	Charles E. Nagl	Le					Marag	gret	Mery D	owne:	У	
Maryland	12 should be find and Mental H		19a. Informant's Name/Relations				-						or Town, State	, Zip Code)
	1 and Healtt em 27		Theresa V. Boye  20a. Method of Disposition	er-sister	20b. Pl		Selem sition (Name matory or other				stown,	,	1/4Z ocation - City	or Town, State
Baltimore,	Pages ment of tant: If It		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	State	thsbur	g Crem	ato	ry			Smit	hsburg	, Maryland
Bal	permit Depar Impor any In		21. Signature of Funeral Service	Zaltan	·	1	331 Ea	Addres .ste	ern B	ity Dot 1vd.	nglas A North	. Fi Hage	ery Fu rstown	neral Home , MD 21742
			23a. Part1. Enter the disease, e shock, or heart failure. Lis	complications that of tonly one cause on	caused the death each line.	. Do not ent	er the mode of	of dying	g, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death
Table 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	eritor	11tis								Oriset and Death
	Examiner			Dué to	(or as a consequ	ence of):	col	·······································	```					
Н	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	ence of):								
	and -trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a consequ	ance of):								
760,	be exician a	al E)	,	Due to	(or as a consequ	ence on:								
9	ifficate g phys as the			d										
P.O. Box	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	tcome pf pregnar birth 2 ☐ Fetal nant at time of de own	death 3	Ectopic preg						23d. Date of o	elivery Day Year
	that ed b deta	<u>a</u>												
~	S E e	>	^ -	ions contributing to d		•				1,		tobacco ι	use contribute	to the cause of death?
oro	requires sen sign rould be	by	^ -			•				l. deax				to the cause of death? Probably 4 □Unknown
Il Records,	aw requi ss been s 2 should	by	^ -	ions contributing to d 36st2 End A		•				1,	1 □	Yes 2	24b. Were prior t	Probably 4 Unknown autopsy findings available o completion of cause of
Vital Record	aw requi ss been s 2 should	Be Completed by	Chrenic  Rheua  25. Was case referred to medical examiner?	obstration A	uctive Hritis	Pu	ligon	ary	26. Place	de 4 x	24a. Was autt peri 1 Yes	Yes 2  s an opsy ormed? 2 No one)	24b. Were prior t death 1 \( \text{Y} \)	Probably 4 Unknown autopsy findings available o completion of cause of es 2 No
or Vital Record	aw requi ss been s 2 should	To Be Completed by	Chrenic Rhema  25. Was case referred to medical	obsta tod A Hospital: 1E 28a. Date	Inpatient 2 Is	•	ligar	Othe	26. Placer: 4 □ N	e of Death	24a. Waaute perl	Yes 2  s an opsy ormed? 2 No one)	24b. Were prior t death 1 1 Y	Probably 4 Unknown autopsy findings available o completion of cause of es 2 No
ion or Vital Record	ing Physician: The law requi After this certificate has been s funeral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner?  27. Manner of Death	obstration A	uctive ettritis	Pus ER/Outpatien	ligar	Other	26. Placer: 4 □ N	e of Death	24a. Was autt peri 1 Yes	Yes 2  s an opsy ormed? 2 No one)	24b. Were prior t death 1 1 Y	Probably 4 Unknown autopsy findings available o completion of cause of es 2 No
Division or Vital Record	ing Physician: The law requi After this certificate has been s funeral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death 1   Natural 5   Pendi	al Hospital: 1 28a. Date (Morning Inglined 28e. Place	Inpatient 2 Is	PLC ER/Outpatien 28b. Time of Injury	ligor at 3 DOA M	Other	26. Place	e of Death	24a. Wa: auto perful 'Yes h (Check only me 5 Res 28d. Describe	Yes 2  s an opsy ormed? 2 No one) sidence how injur	24b. Were prior to death 1  Your occurred	Probably 4 Unknown autopsy findings available o completion of cause of es 2 No
Division or Vital Record	ing Physician: The law requi After this certificate has been s funeral director, page 2 should	Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi Invest 3 Suicide 6 Could detern  29a. Certifier 1 Certifyi	al Hospital: 1El 28a. Date (Mor igation not be nined 28e. Place build ng Physician: To the Examiner: On the base of the properties of the	Inpatient 2 For Injury At horing, etc. (Specify be best of my known as the surface of the surfac	ER/Outpatien 28b. Time of Injury me, farm, str.)	at 3 DOA	Other	26. Place Pr. 4 \( \text{N} \) Yes 2 \( \text{The me, date a} \)	e of Death ursing Ho	24a. War autroper 1	s an ppsy ormed? 2 1 100 one) idence how injure (Street an wwn, State e cause(s);	24b. Were prior to death of the cath of th	autopsy findings available o completion of cause of ess 2 No necify)
Division or Vital Record	ing Physician: The law requi After this certificate has been s uneral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi invest 3 Suicide 6 Could deterr  29a. Certifier 1 Check only 2 Medica	Hospital: 1 28a. Date (Mor gigation not be nined 28e. Place build and Physician: To the I Examiner: On the band mar	Inpatient 2 E of Injury th, Day Year)  e of injury - At horing, etc. (Specify, etc.)	ER/Outpatien 28b. Time of Injury me, farm, str.)	t 3 DOA  f 28c  M eet, factory, c	Other	26. Place Pr. 4 \( \text{N} \) Yes 2 \( \text{The me, date a} \)	e of Death ursing Ho	24a. War autroper 1	s an opsy ormed? 2 100 one) sidence how injure (Street an own, State e cause(s), date and 29d. Date 120 one) 29d. Date 120 one	24b. Were prior to death 1  Y.  6  Other (S) ry occurred and Number or 3)	autopsy findings available o completion of cause of ses 2 No  Decify)  Rural Route Number,  as stated, ue to the cause(s)

WH-5

State Registrar

APR 0 9 2008



AVE HAGERSTOWN MD21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Amend#20b.&c.PerFHPGC4-7-08cm 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** р м Russell Lee Nelson 4/2/2008 3:29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Days Hours Min Director 215-38-0498 67 9/26/1940 Crisfield, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 To Yes 2 □ No Prince George's Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5413 Upshur Street 20710 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 X No ģ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Inc. 2006. Architect of the Capital 12 Electrician 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon R. Nelson Mary F. Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise B. Nelson, Wife 5413 Upshur St., Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 4/5/2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Canrwy Gasch's Funeral Home, P.A. Hyattsville, MD 2078 23a. Part 1. Enter the disease, or complications that caused the death. Do her enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Pulmonary Arrest /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or se a consequence of) Thoracic Anyrsm Due to (or as a consequence of) Physician/Medical Systemic Hypertension 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 29 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 X ER/Outpatient 3 □ DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

P.O. Box 68760. Division of Vital Records.

executed and burial-trai attending physician for use as the buria I or Attending Physician: The law requires that the death certificate be eather death.

Director: After this certificate has been signed by the attending physiciar ed by the a signed I the funeral in by filled

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

Hospital 24 hours a within 2 To the I

completely State

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
April 4,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3415 Hamilton Street, Steven Tee Hyattsville, MD 20782

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

2008

Registrar

			1 - For State Registrar	State	of Marylar			nt of H				giene Reg. No.	008	12	883
ļ	Physici /Medio		1. Decedent's Name (First, Midd Norma Le	, ,	dmc						2. Date of Dea Month April	Day	Year 2008	3. Time 3:1!	of Death
	Examir		4a. Facility Name (If not institution  Dorchester Ge		· ·			y, Town, or ambri		n of Death			ounty of Dea	th	•
	Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday) Yrs.		er 1 Year			8. Date of Birt (Month, Da Sept. 2	h y, Year)	9. Bir	thplace (State ountry) ryland	e or Foreign
	P.		Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo	cation		1		DOPO -	, , , ,		10d. Inside	City Limite
$\bigcirc$	Maryle f shor ied at	tor		chester	100.01	cy, rount of Le		Churc	h Cr	eek					es MINo
ζ	h the or 28a-	irect	10e. Street and Number				10f. 2	Zip Code				10g. Citize	n of What Co	ountry?	
3	ath wit	ral D	1508 Hip Roc	f Road					613				USA		
36.	be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorce	ried Armed F	2 XNo ive			edent of Hoecify Cuba 2 🔀 No	ispanic C an, Mexic Specif		ecify Yes or No- Rican, etc.)		Black, Whi	erican Indian, te, etc. white	
15-0036	n 72 hou "natura lecical E	Completed I	15. Deceder (Specify only highe	nt's Education est grade completed	)	16a. Dece	dent's Us kind of I	sual Occup vork done o use retired	ation during mo	ost of work	ing	16b. Kind	of Business	/Industry	
212	filed within 72 Hygiene. <b>yther than "na</b> ent, the Medic	mo.	Elementary/Secondary (0-12)	College	(1-4or 5+)			emake				C	wn hor	ne	
	ild be filed lental Hygic ked other ic event, the	Be	17. Father's Name (First, Middle	•							First, Middle,		•		
Maryland	should by and Ments marked umatic ev	ြင	Norman Rano		en	19h Mailin	na Addra	ss (Street			e Olive			Zin Codol	
<u>⊠</u>	a s a		Kay Bradshaw		ghter	1	-				l, Churc				22
altimore,		15	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Fil Romoval from	20b.	Place of Dispo cemetery, cre-	osition (N	ame of r other plac	:e) :	[	Date	20c. Loca	tion - City or	Town, State	
Ĕ	: Pages tment of tant; If Its	١,	4 ☐ Donation 5 ☐ Other (	Specify)	st.	John's		-			/08	Chur	ch Cre	eek, MI	)
Ra	permit. Page Department ( Important: If any Injury or		21. Signature of Funeral Service				700		t St	., Ca	omas Fu mbridge	, MD	. Home 2161		
)	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Se	caused the deareach line.	quence of):					or respiratory a	rest,		Approxim Interval B Onset and 2d3	etween
8/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	or as a consec	ence of :	-200511								
O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live	utcome pf pregn birth 2  Feta nant at time of conown	aideath 3[	⊒Ectopic ⊒ Other	pregnancy (specify)	′			23	d. Date of de Month	livery Day	Year
λ, J	ss that gned b	by Pt	Part II. Other significant condit							t i.	23e. Did to	obacco use	e contribute t	o the cause o	f death?
ora	requir een si tould b	ted	Clostridiu		rate	-DHD5	, C	cron.	3ry		1   1	Yes 2□	No 3∏P	robably 4	Unknown
al Record	The lar	Completed	artery o	Liseasc.							24a. Was autop perfo 1□ Yes		24b. Were a prior to death? 1 ☐ Yes		s available cause of
VItal	sician certifi irector	Be c	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hoopital	Inpatient 2	I EB/Outpotion	•• 0□	Oth	or:		h (Check only o				
פר	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date		28b. Time o		28c. Injur Worl	411		me 5 Resident			ecity)	
UNISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illied in by the funeral director,	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	gation not be 28e. Place	e of injury - At h ding, etc. (Speci	ome, farm, sti	M reet, fact	1 🗆	Yes 2[		28f. Location (8 City or Tox	Street and i	Number or F	Tural Route Nu	umber,
_	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Ce		ng Physician: To the Examiner: On the and ma											∋(s)
)	To th within	Me	29b. Signature and title of certific	son.	do		2	9c. Licens						th, Day, Year)	)
	つ		30. Name and address of person	100 B	ramble	25+	Print)	Car	nbr	ida	3 e MI	5			
	Sta	ite	31. Date filed (Month, Day, Year	7 2008 32.	Resistrar's Sign	ature &									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elisabeth olsen tedy 12:30 P™ 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Waldorf 200 Garner Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 5, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2XF Hungary 88 Director 127-26-9054 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes XX No ral", or Items 23a or 28a-f sh Examiner must be notifled Director MD Charles Waldorf 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 20602 "natural", or Items 23a 200 Garner Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Itel any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Soltesz-Nagy Joseph\_Fulei-Szantho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Copley Avenue, Waldorf, MD 20602 Nancy Dove/ Custodian Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr.4, 2008 Waldorf, MD Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Huntt Funeral Home M01436 3035 Old Washington Rd., Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner <u>Hypertensive</u> Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by severe dementia; renal insufficiency, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of breast cancer, chronic anemia 24a. Was aп autopsy performe death? 1 □ Yes 2 No 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼No ۴ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3,2008 D 28035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BBID 9135 Piscataway Rd, Ste. 310, Clinton, MD 20735 Basirmohmad F. Kolia, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1300 M **Physician** Terri Suzanne Pinnell 200 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Annapolis 918 Madison Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 7 1 1 9 4 3 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Orlando FL 1 □ M 2 🗓 F 65 287 38 3930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r then "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 X Yes 2 No MD Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21403 USA 918 Madison Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 Yes 2 X No Specify δ 3 ☐ Widowed 4 A Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 is marked other then College (1-4or 5+) 5+ Elementary/Secondary (0-12) Program Analyst DEA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marcella Theresa Vanderbilt Donald Bowen Brummel traumetic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Pinnell (son) 22372 West Cantilever Ct/Buckeye AZ 85326 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ö permit. Pagé Department of Importent: If eny injury or once. Metropolitan Crematory 4/4/08 Alexandria VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Advent Funeral & Annapolis MD and Cremation Services Falls Church VA Wilhelm Melane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teriosclerotic **Physician** /Medical Examiner pertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. physician attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Tyes 2 Myo 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9☐Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ģ 1 Yes 2 No 3 Probably 4 Inknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No or Attending Physician: : After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Certification: To Division of 28c. Injury at Work? Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A cympletely filled in by the fu investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only Deputy 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 0 4 2008

ones 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0605

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2,2008 Year **Physician** 9:33a Beatrice E. Petrelli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurelwood Care E1kton Ceci1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | 9. Birthplace (State or Foreign August 10, 1917 | PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 90 Yrs. Director 137-14-3737 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show the Medical Examiner must be natified at 1X Yes 2 ☐ No Director Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 100 Laurel Dr. 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3€ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If item 27 is marked other the 10 Household <u>Housewife</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward S. Buckalew Ethel Plank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1613 Benjamin Ct., Bear, DE Date 20c. Loca Joan Janik/Daughter 19701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 4, 1 Burial 2 Termation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris Inc. West Chester, PA 2008 21. Signature of Figneral S. Nice Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest.

MD
shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALLUNE TO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying | hysicial: To the best of my knowledge, Jean observed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical E aminer: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D54073 Tlou 30. Name and address of lerion who completed cause of death (Item 23a) (Type, Print) NEWLATE DE 19720 817 ARIEN STONE CHURCHMANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2008 Registrar

State Registrar DHMH 17 Rev 1/2001 29b. Signature and

31. Date filed (Month, Day, Year)

of certifier

APR 2 1 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)
PLANCEN BILARUM, AD 196 TO DUUE, FAED ENICE, MD 21702.

Registrar's Signature

29c. License number

00062123

29d. Date signed (Month, Day, Year)

April 15, 2008

08-02736 Lucious Pulliam Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 12888

acious i umam	1-1 Re	For State gistrarAmend#1_PerMEOPGC4-1Sertificate of Death Decedent's Name (First, Middle, Last)		Reg.	No.	To The Court					
Physician/	1.	Decedent's Name (First, Middle, Last) Lucious Jyhoida Pulliam		Date of Death Month Da Dril 7, 2008	ay Year	3. Time of Death 1228 hrs					
ledical Examiner		Lucious Jyhoida Pulliam  a. Facility Name (if not institution, give street and number)  4b. City, Town, or Locati	(prii 7, 2000	4c. County of Death							
	,.	607 Southern Avenue #101 Oxon Hill			Prince Ge	<u> </u>					
Funeral	5.	Social Security Number 0. Sex 7: Age (iii ) 15: lest six 1165)	Under 24Hrs. 8 lours Min.		MM/DD/YYYY) (	9. Birthplace (State or oreign North					
Director	[	578–58–3798 X M 2 F 63 Yrs. White		07/20/19	44	County Carolina					
any	_	sual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
		MD PG Oxon Hill				1 Yes 2 No					
ihe Maryland t or 28a-f show iffed at once. Director	1	0e. Street and Number 10f. Zip Code		10g.	10g. Citizen of What Country?						
the M 3a or 2 otified		607 Southern Avenue #101 20745			USA	American Indian Block					
or items 23	1	1. Marital Status 1. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? ( Spec xican, Puerto Ri	ify Yes or No- can, etc.)	14. Race -	American Indian, Black, etc.					
er deat		1 X Yes 2 No 3 Wildowed 4 Divorced If Yes, Give Year 65-67 1 Yes 2 X No spe	ecify:		Specify: B	lack					
75 To hours after death with the Maryland n"matural", or items 23a or 28a-f sheat Examiner must be notified at once detect by Funeral Director	? -	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Cduring most of working life. DOI during most of working life.	k done 1	6b. Kind of Busi	ness/Industry						
5-0036 led within 72 hours af tygiene. other than "matural the Medical Examin		Elementary/Secondary (0-12) College (1-4 or 5+)		"	Federal Covernment						
5-003 ed within lygiene. other th. th. Medi		2 1000	irst, Middle, Ma	st, Middle, Maiden Surname)							
		Lucious Pulliam	Willie Be								
21215 rould be fill d Mental H is marked tite event, t		19a. Informant's Name/Relationship (Type, Print )									
e, MD 1 and 2 shr Health and item 27 is		Shelley Merchant - Daughter 9721 Cadwell Street  20a. Method of Disposition (Name of cemeter		Date	20c. Location - 0	City or Town, State					
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental. Inner: If item 27 is marked or other traumatic event,		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	5/2008	8 Cheltenham, Manyland							
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other t	1 2	4 Donation 5 Other Specify: Maryland Veteran Cemetery  22. Name and Address of Facility Freeman Funeral Services									
Ba perm Dept Imp	- (0	4594 Beech Road	d; Temple	Hills, M	aryland	20748					
Physician	72	23.) art I. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such failure. List only one causer on each line.			st, snock, or nea	Between Onset and Death					
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovasc or condition resulting in death)  Due to (or as a consequence of):	cular Dis	ns:							
	1	Sequentially list conditions, b.									
	<b>~</b> □	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
_ = =		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
cecuted	<u>#</u>  -	d.  X UNPENDED ☐ AMENDED 23a, Pt. II, 27 per ME g878 4/22/0	08 amb								
760, cate be execut physician and he burial - tra	Medical	F FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	delivery					
5876 rtifical ling ph		23b. Was decedent pregnant in the past 12 months?	Ectopic pregnan	су	Month	Day Year					
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as the standard of the control of the detached for use as the standard of the control of the detached for use as the standard of the detached for use as the standard of the standard of the detached for use as the standard of the standard o	Physician	1 Yes 2 No 9 Unknown 9 Unknown									
at the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	en in Part I.			bute to the cause of death?					
ires thr	<u>ğ</u>	Chronic Alcohol Use		1 Yes		Probably 4  Unknown  Vere autopsy findings available					
ords w requ	Completed by			autops perfor	sy   r	prior to completion of cause of death?					
Recort the la	ĕ			1 ✓ Yes 2		✓ Yes 2 No					
cian: certifi ector,	8	25. Was case referred to medical	Death (Check o		Residence 6	✓ Other: Scene					
of Vi	앍	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury a			now injury occurr						
Sion C Attending death. ector: Af	틹	5 Penation	2 No								
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death.  "al Director: After this certificate has been signed by the funeral director, page 2 should be deach the in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	ding, etc.	28f. Location (S or Town, S		er or Rural Route Number, City					
Di ospital hours a meral	S E	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, and	due to the caus	e(s) and manne	r as stated.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - transicial properties of the purial completely filled in by the finneral director, page 2 should be detached for use as the burial - transicial properties of the purial completely filled in by the finneral director, page 2 should be detached for use as the burial - transicial properties.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	leath occurred a	t the time, date	and place, and	due to the cause(s)					
To the within To the comple	₩.	and manner stated.  29b. Signature and title of certifier  29c. License n			_	ned (Month, Day, Year)					
		Caroe Hallan O.C.M.		April 8, 20	U8 						
RVA	Ì	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e. MD 2120	1							
R VA	10		.,								
Sta Registr	rar	31. Date filed (Month, Day Year)  APR 1 5 2008  32. Registrar's Signifure									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 2008 March 29, **Physician** Findlay Paydon Joseph 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Fruitland 205 S. Camden Ave. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 216-36-5351 Director Missouri 93 6/10/1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Maryland Wicomico Fruitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21826 USA 205 S. Camden Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: Navy 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 professor education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Stephen Paydon Sybilla Findlay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 S. Camden Ave., Fruitland, MD 21826 19a. Informant's Name/Relationship (Type. Print) Jonathan Paydon/son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4/2/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21826 23a. Part1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as preparation arrest, shock, or heart failure. List only on preparation uses a each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۴ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. O. ے Records, Division or Vital Hospital or Attending

> State Registrar

29a, Certifier

(Check only one)

e and a

29b. Signature and tiple of certi

2 Medical Examiner:

3 2008

and manner stated.

mo

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

POBOX49

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D 20441

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Stlisbury

4-4-08

31. Date filed (Month, Day, Year)

APR 02

30. Name and address person who impleted cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Director

by Funeral

Completed

Be (

2

Examiner

Physician/Medical

Medical Certification: To Be Completed by

**Physician** /Medical

Examiner

**Funeral** Director

For State Registrar		Cert	tifica	te of L	Death		Reg	No.	000	1000
Decedent's Name (First, Middle, Las	st)				<del></del>	2.	Date of Death	hou	UUC	3. Time of Death
Earl	wing Ri	11				1	Month :	Day	2003 gear	7:17 A M
Facility Name (If not institution, give	e street and number)	2/	4b. City	, Town, or	Location of Deat	h		4c. C	ounty of Dea	- 1/
Carcoll	Haskella (on	7-1		W	estmins	ten			CALL	011
Social Security Number 6. S		**	If Unde	r 1 Year Days	If Under 24 Hrs Hours Min.	. 8.	Date of Birth (Month, Day, Y	ea <i>r)</i>		rthplace (State or Foreign
219-34-4201	ZM 2□F 70	Yrs.		, -			12/01/			
ual Residence of Decedent  1. State 10b. County	10c C	ity, Town or Loc	ation				,,			10d. Inside City Limits
MD Carroll		estminst								1 Tyes 2 No
Street and Number	WE			p Code			100	Citizo	n of What C	
. Street and Number 26 Bella Vita Com	irt		101. 21		157		109	USZ		ountry:
	12. Was Decedent Ever in U	IS 12 W	Jas Door		ispanic Origin? (S	Sneoif	/ Ves or No			erican Indian,
Marital Status 1 □ Never Married 2 □ Married	Armed Forces?  1 Xes 2 No		Yes, sp	ecify Cuba	in, Mexican, Puer	to Ric	an, etc.)	'*	Black, Wh	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1955	5-62	☐ Yes	<sup>2</sup> No	Specify:			S	pecify:	nite
15, Decedent's Ed	ducation	16a. Decede					16	b. Kind	of Business	
(Specify only highest gra	de completed)	I (Give k	and of w		during most of wo	rking				•
lementary/Secondary (0-12)	College (1-4or 5+)	H	Iouse	e pai	nter			pa:	intino	ſ
Father's Name (First, Middle, Last)	l				18. Mother's Nai	me (F	irst, Middle, Ma	_		
Melvin Earl Ril	l				Jennie	e Hi	ughes			
a. Informant's Name/Relationship (	Type. Print)	19b. Mailing	Addres	s (Street	and Number or R			ity or 1	Fown, State,	Zip Code)
mma Christina R		26 Be	ella	Vita	Court,	Wes	stminst	er.	MD. 2	21157
. Method of Disposition		Place of Dispos	ition (Na	me of	1	Date		<u>_</u> _		r Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cemetery, crem crroll C			i .	13/	2008 На	amre	stead,	БМ
Signature/of Funeral Service Licer					ss of Facility E1					rm.
Mando P		93	84 S	. Mai	n Street	- I	z runera Hampste	ag -	Md. 2	21074
a. Part1. Enter the disease, or com	plications that caused the dea					_		•		Approximate
shock, or heart failure. List only mediate Cause (Final	one cause on each line.			2	. 5.					Interval Between Onset and Death
ease or condition ulting in death)	a Due to (or as a conse	quence of:	2	1	1)					5000
	Due to (or as a conse	quence oi).								
quentially list conditions,	b. Due to (or as a conse	quence of):								
ny, leading to immediate ise. Enter Underlying										6
t initiated events ulting in death) Last	c Due to (or as a conse	uence of):								
	_d									
FEMALE:	23c. If yes, outcome pf pregr	ancy					2.0,	22	d. Date of de	elivery
in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	al death 3 🗌	Ectopic p	oregnancy specify)	,			23	Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		20101 (3							
t II. Other significant conditions of	ontributing to death but not re	sulting in the un-	derlying	cause give	en in Part I.		23e. Did toba	co use	contribute	to the cause of death?
							1 ☐ Yes	2	<b>√</b> 0 3 🗆 F	Probably 4 Unknow
						I	04= 141	1	0.41- 111	
							24a. Was an autopsy performe		24b. Were a prior to death?	autopsy findings available completion of cause of
								No	deatn? 1 ☐ Ye	
Was case referred to medical examiner?	Hospital:						Death (Check only one)			
1 ☐ Yes 2 ☐ No		ER/Outpatient			4 LI Nuising i	_	5 ☐ Residend			ecify)
Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injur Worl		28d	l. Describe how	injury	occurred	
2 Accident investigation			M		Yes 2 □ No					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At I building, etc. (Spec	nome, farm, stre	et, facto	ry, office		28f.	Location (Stre City or Town,		Number or F	Rural Route Number,
	ysician: To the best of my kr niner: On the basis of examir									
(Check only 2   Madical Ever					idirion destrica				ilace and di	ie to the called(e)
(Check only 2 Medical Exar	and manner stated.	adon and/or my	esilgalio	n, in my u	pinion, death occ	urrea	at the time, dat	е апа р	olace, and di	ue to the cause(s)

State Registrar

00059943

			1 - For State Registrar	State of Ma	ryland /		artment of F		nd Mental H	ygien Reg. N	0000	12891	
			Decedent's Name (First, Middle, Last)						2. Date of D	Death		3. Time of Death	
3600	Physici /Medic		Ella Jane Raines						March	31	2008	12:26 PM	
	Examin		4a. Facility Name (If not institution, give s				4b. City, Town, o	r Location of	Death	4	c. County of Death		
	The second leading and the second		Johns Hopkins Bayvi				Baltimo						
2	Funeral Director		5. Social Security Number 6. Sex 224 − 16 − 0488 1□  Usual Residence of Decedent	7. Age	e (In yrs. last I 87		If Under 1 Year Months Days	If Under 2	Min. (Month, I	Birth Day, Yea B, 1	Coui	place (State or Foreign ntry) ¡inia	
	vland ow at		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits	
	e Mary 3a-f sh tiffied a	Director	Maryland		Balt	imor	e					1 X Yes 2 No	
	th with the 23a or 23 sst be no		10e. Street and Number 1014 Iris Avenue				10f. Zip Code 21205			_	itizen of What Coul ced State	•	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S.  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 No Specify:				in? (Specify Yes or N Puerto Rican, etc.)	NO-	14. Race - Americ Black, White, Specify: Whi	ite, etc.	
Maryland 21215-0036	"natura "natura edical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16	a. Deced	lent's Usual Occup	ation during most	of working	16b.	Kind of Business/In	dustry	
7	within iene. than the Me	dmo	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Give kind of work done during most of working life. DO NOT use retired)  factory worker  ma								nufacturing		
פר	e filed al Hygi other vent, t	BeC	17. Father's Name (First, Middle, Last)							e, Maiden Surname)			
<u>Na</u>	should be f and Mental H s marked ol umatic ever	To E	John Reed Stone					Maggi	e Mize				
Var	12 sho		19a. Informant's Name/Relationship (Typ	,	- 1		ig Address <i>(Street</i> Fox Run I		r or Rural Route Nun		or Town, State, Zip ennsylvan		
a)	1 and Healti em 27	- 5	20a. Method of Disposition	51 - 5011	20b. Place	of Dispo	sition (Name of	i	Date		ocation - City or To		
Baltimore,	Pages ment of I ant: If ite ury or o		1 MBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other ( <i>Specify</i> )	emoval from State	ceme	Roc	natorý or other plac k Cemete:	cy A	pril 4, 2008,	Bu	tler, Mar		
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	ws-	M0107	2 9	. Name and Addre	ss of Facility Main	Eline Fu Street H	nera amps	l Home tead, Mar	yland 21074	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused e caus, on each lin	the death. De			-		arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	VENT	KILLI	LAI	e JAC	CHYL	ARDIA			Onset und Death	
	Examiner			VENTRICULAR TACCHYCARDIA  Due to (or as a consequence of):  ATRIAL HBRILLATION									
	• ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  MULTIPLE MYELDMA  Due to (or as a consequence of):									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	MULT Due to (or as s	1 1 11	e of):	MYE	LOM	A				
8760,	cate be executed obysician and the burial-transit	dical E	L <sub>d</sub>	ANEMIA									
Ö	ntifica ng ph		IF FEMALE:										
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregrant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome   1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)	<i>y</i>		-	23d. Date of deliv Month	ery Day Year	
P.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions conf	tributing to death bu	ıt not resulting	in the u	nderlying cause giv	en in Part I.	23e. Dio	d tobacco	use contribute to t	he cause of death?	
Sign	w require been sig should b								1	] Yes	2 No 3 Prol	bably 4-Tunknown	
Records,	Physiclan: The law r this certificate has be ral director, page 2 sh	Completed								topsy rformed?	prior to co death?	opsy findings available ompletion of cause of	
Vital	ctor, p	Be C	25. Was case referred to medical examiner?			•		26. Place	of Death (Check only				
or \	hysic this co	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatie				4 LI Nurs	sing Home 5□Re			fy)	
lon	ding After fune	ation:	27. Manner of Death 1	28a. Date of Injur (Month, Day	Year) 28b	. Time of Injury	Wor	yat k? Yes 2 □ N	28d. Describ	e how inj	ury occurred		
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injubuilding, etc	ry - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or 7	(Street a own, Sta	and Number or Run te)	al Route Number,	
	ie Hospii 24 hour ie Funera letely fille	Medical (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination	ge, deati and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and due to the hoccurred at the time	ne cause e, date a	s) and manner as s nd place, and due t	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier		, ,		29c. Licens	e number	. 00	29d. D	ate signed (Month,	Day, Year)	
	NI		Sauvaule	Sulk	MI	)	1).	2/1	88	4	11/08	'	
	3		30 Name and address of person who cor	npleted cause of de	eath (Item 23a	(Type,	Print) Pl	200	Drund	1110	NO :	71222	

State Registrar

31. Date filed (Month, Day, Year)

nth, Day, Year)

APR 0 2 2008

APR 0 2 2008

			1 - State Registrar	State of Ma	-	•	riment of t		Mental Hy	/gierie Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of D	eath Day	Year	3. Time of Death
	/Medic		William T. Rid						Marra	1 31	2008	11:30 A.M.
	Examir	er	4a. Fecility Name (If not institution, give	e street and number)				or Location of Dea	ith		County of Death	
	Funeral		BWMC 5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last bir	nthday)_	Glen B	If Under 24 Hr	s. 8. Date of Bi	irth	nne Ar	place (State or Foreign
	Funeral Director		218-12-9090	<b>∑</b> M 2□F	90	Yrs.	Months Days	Hours Mir	May I	8 19	17 Ma	ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Maryl	Į.	Maryland Anne A	runde1	Gamb	bri1	.1s				:	1 ☐ Yes 2X No
2	or 28s	lirec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
E	23e c	ralD	2540 Brickhead	Rd.			210				USA	
38	within 72 hours after death with the Maryland ene. then "natural; or items 23e or 28e-f ehow he Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of I Yes, specify Cub □ Yes 🏋 No	Hispanic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or N into Rican, etc.)		14. Race - Ameri Black, White Specify: B1	, etc.
1215-0036	2 hou	ted	15. Decedent's Ed	ducation	16a.	. Decede	ent's Usual Occup	pation during most of wo	odina	16b. Kir	nd of Business/Ir	ndustry
215	d within 72 ho giene. ir than "natu ina Medical	Completed	(Specify only highest gra	College (1-4or 5	i+)	life. D	O NOT use retire	ed)	orking			
		S	6th  17. Father's Name (First, Middle, Last)	0			<u>lechani</u>	T	ame (First, Middle		rvice	Center
Amy yland	d be filed antal Hygi ced other c event, I	Be c	Thomas Tyler R						France			
14 Am	2 should be f and Mental I is marked of	P	19a. Informant's Name/Relationship (		19b	. Mailing	Address (Street	t and Number or F				ip Code)
	C 2 44 F		Thomas H. Ridg	ley(Son)	51	16 F	Rossite	er Ave	Baltim	ore,	Md. 2	1212
Wil Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	f Disposi ry, crema	ition (Name of atory or other pla	ice)	Date	20c. Lo	cation - City or T	own, State
يَّ ح	Pages ment of lant: if it		4 Donation 5 Other (Specify		Mt. T		r UMC	1	5-08			le, Md.
Ball	permit. Page Depertment of important: if any injury or ance.		21. Signature of Funeral Service Licen		1 ~1-1-1	7.000		St. Ar				0.1
	40244	_	23a. Part 1. Enter the disease, or com	eese MO							.u. 214	
	Discontinue		shock, or heart failure. List only	one cause on each lin	10.		<del> </del>	1	ac or respiratory :	urrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	ot):	em -	Janne	<u>د</u>			
	Examiner			Coros	1 hus	W.	tems	Veis	egu			
	₽ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence	of):						
	tificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		-4).						
60,	be ex icien a burial		Totaling in obtain, East	Due to (or as	a consequence	or):						
68760,	ficate physis the	edical		d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	۰۰				2	3d. Date of deliv	/ery
a.	that the death cer ed by the attendir detached for use	by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death time of death		Ectopic pregnanc Other (s <i>pecify</i> ) _	ÿ 			Month	Day Year
P. 0.	at the d by th etache	Phys	9 🗆 Unknown									
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death cer death. setor: After this certificete has been signed by the attendin by the funeral director, page 2 should be detached for use	l by	Part II. Other significent conditions of	ontributing to death b	ut not resulting ir	n the und	derlying cause gr	ven in Part I.		tobacco u		the cause of death?
Sor	law requires as been sign 2 should be	letec							24a. Wa			/ \
Be.	The tay ie has age 2	Completed	-						auto	opsy formed?	death?	opsy findings available ompletion of cause of
ital	ician: Th certificete ector, pag	BeC	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only	one)	1 L Yes	2 No
>	hysic this ce al direc	ToE	examiner? 1 ☐ Yes 2 No	Hospital: Inpatie	nt 2 ER/Ou	utpatient	3□ DOA Dt	hor	Home 5 Res		S □Other (Spec	ify)
0	ding Pl	 	27. Magner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry y Year) 28b. 1	Time of Injury	28c. Inju Wo	rk?	28d. Describe	how injury	y occurred	
isio	ttend death stor: /	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		uni - At homo in	arm oten		]Yes 2 ☐No	284 Logation	(Street and	d Number or Du	ral Route Number,
Div	for A after Direction by	Certification;	4 Homicide determined	building, etc	c. (Specify)	arm, sirei	et, lactory, office		City or To	own, State	)	al hoble whitber,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	dical C	29a. Certifier (Check only Medical Exam	ysician: To the best of	of my knowledge	e, death	occurred at the ti	me, date and place	ce, and due to the	e cause(s)	and manner as	stated.
	To the H within 24 To the F complete	Medi	one)	and manner sta	ited.		.~					
	5 ¥ 5 50	9	29b. Signature and title of certifier	h	11		29c. Licens	se number		29d. Date	e signed (Month	Day, Year)
	NA PAR		30 Name and	//	KU (14 = 22=)	/Tues C	1)4	37//	-	14 Jan	M 3/	2008
	NA		30. Name and address of person who	n. 20	eath (item 23a)	Diw	E, Cile	nbum	ne. m	1. )	orphi.	
4	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	1	1010				-1001	
- 6	Registr	ar	APR 0 4 20	UN Come	- X	400	ME)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11, 2008 ar **Physician** April Linda 4:05 AM Rose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College View Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 65 163-34-4481 Pennsylvania December 12, 1942 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Adamstown 1 □Yes 2 X No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21710 United States 5721 Nottingham Place Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired.

Customer Service
Dispatcher Elementary/Secondary (0-12) College (1-4or 5+) Comcast 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Morris Louis Mackson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5721 Nottingham Place, Adamstown, Maryland 21710 Doylette Harrison Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Monongahela Cemetery 17, 2008 North Braddock 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Runeral Home 106 Fast Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Et. I Down Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed ending physician and use as the burial-trai Due to (or as a consequence of): Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 1 ☐ Yes 2 ☐ 🖊 6 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I or Vital Records, Completed by di due: 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t irector, page 2 s autopsy performe 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Division 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah lhomas MIN 32. Regis Ar's Signature 31. Date filed (Month, Day, State 2008 Registrar

Dic

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2000
	Dhusisi		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month: 1 1 Daybood Year  1. Daybood Year  1. Daybood Year  1. Daybood Year  1. Daybood Year
	Physici /Medio		Debora Ann Sanders April 1, 2006 11:33 am
	Examir	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Emmitsburg  4c. County of Death  Frederick
The state of the s	Funeral Director		5. Social Security Number 213-60-7820  6. Sex 1 M 2 F F F F F F F F F F F F F F F F F F
	put M		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryla f sho	tor	Maryland Frederick Emmitsburg 1™Yes 2□No
	n with the 3a or 28a st be notif	al Director	10e. Street and Number 331 N. Seton Avenue 10f. Zip Code 21727 10g. Citizen of What Country? USA
336	4 within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
121	within iene. than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+)  Physical Therapy Assistant  State of Maryland
	be filed Ital Hyg Id othe event,	To Be Co	17. Father's Name (First, Middle, Last)  John Clifton Dick  18. Mother's Name (First, Middle, Maiden Surname)  Marianne Gochenour
Maryland	and sand sand	F	19a. Informant's Name/Relationship (Type. Print)  Marianne Myers, mother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  PO Box 992, 331 N. Seton Ave, Emmitsburg, MD 21727
Baltimore,	97		20a. Method of Disposition    Date   Control of Disposition   20b. Place of Disposition (Name of Souther ry, crematory or other place)
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers—Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727
	Physician /Medical Examiner		23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)  Dui (or is a consequence of):  Sequentially list conditions  D
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Se juentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).  c. Due to (or as a consequence of):  to your and death of the consequence of the cons
.O. Box	at the death certific by the attending partached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome pf pregnancy   23d. Date of delivery   23d. Date of delivery   Month   Day   Year   Year
rds, P.	quires that in signed build be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
l Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: These is a PER Outsetient of P
Ö	Phys this ral dii	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Division	l or Attending Ph after death. Director: After th d in by the funeral	Certification:	Natural   5   Pending   (Month, Day Year)   Injury   Work?   1   Yes 2   No   Note that Injury   Yes 2   Note that Injur
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in I	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th compl	Me	29b. Signature and title of cartifler  29c. License number  29d. Date signed (Month, Day, Year)
	W37		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Alan L. Carroll MD 310 South Seton Ave. Emmitsburg, MD 21727
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 0 3 2008

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State o	f Marylan	•	ertment of I tificate of		d Mental I	Hygiene Reg. No.	0.8	12895	
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)			2. Date of Month			3. Time of Death			
	/Medic		BEATRICE	Apr	1 2	800	3:30 PM						
	Examir	ıer	4e. Facility Name (If not institution, gi	, or Location of D		ity of Death							
_			12010 Chesterton 5. Social Security Number 6.		7. Age (In yrs.	last histoshul	If Under 1 Year		Marlboro		e Geo		
	Funeral Director			1 □ M 2 🛣 F	7. Age (III yrs. 94	Yrs.	Months Days		Min. July	f Birth , <i>Day, Year</i> ) 7 • 1913	Goul MI	place (State or Foreign ntry)	
	υ		Usual Residence of Decedent						July	7, 1913	F11		
	rylan thow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	8a-f s	cto	MD Prince	Georges	Up	per_Mar	1boro					1 ☐ Yes 2 🔯 No	
	vith th	Pre-	10e. Street end Number				10f. Zip Code			10g. Citizen o		ntry?	
	s 23s	eral	12010 Chesterton	1	alone Francis II	0 10 1	20774		0.40	USA		and Indian	
20	should be filed within 72 hours efter death with the Maryland nd Mental Hygiene. marked other than "netural", or items 23a or 28a-f show imstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ X Widowed 4 □ Divorced	edent Ever in U, rces? 2 \square No re ates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2K∑ No		? (Specify Yes o ruerto Rican, etc.	Spec	can Indian, etc. ack			
ž	2 hou	B	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	pation		16b. Kind of			
21215-0020	vithin 7. ne. han "n	Completed	(Specify only highest gr	ade completed) College (1	-4or 5+)		kind of work done OO NOT use retire	working					
	filed v Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Lesi	')		House	keeper	18. Mother's	Name /First Mid	Own H			
Maryland	Ø E O >	o Be	Willie Brown		ecca Por								
<u> </u>	12 should but and Ment is marked raumstice	으	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street			Poute Number, City or Town, State, Zip Code)			
	and 2 salth a n 27 is er trai		Carol Taylor-gra	ndaughte	er	3502 S	Sharonwoo	od Rd #	2D Laur	el, Md.	20724		
altimore,			20a. Method of Disposition		20b. P		sition (Name of patory or other pla		Date	20c. Location		own, State	
Ĕ	Page nent ant: If ury ol		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		Pk Crem		4-7-2	008 Rive	erdale	e, MD.	
palt	permit. Pages 1 Department of H Important: If Iten eny injury or ott		21. Signature of Funeral Service Lice	nsee )	HI		Name and Addre Irray Fur 804 Georg			shington	, DC	20011	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician / /Medical		immediate Cause (Fina)										
	Examiner		disease or condition resulting in death)  Advanced Dementia m  Due to (or as a consequence ot):										
-	D #	Je.			540 (0	. 45 4 55115541	301100 00,						
	ficate be executed physician end is the buriel-transit	dical Examiner	Sequentially list conditions,  Due to (or as a consequence of).										
8/00,	be ex	a E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
0	certificate iding physise as the	/Medic											
. box	death certifi e attending   ed for use as	Physiclan/Me	Part li. Other significent conditions of	Did tabecca use a	use contribute to the ceuse of death?								
5	at the by the stache	ž	•				aony mg oaaco g			1 ☐ Yes 2¾ No 3 ☐ Probably 4 ☐ U			
as, I	es the	À A									7		
ecora	e law requires that the death certifi hes been signed by the attending ge 2 should be detached for use as	Completed							24a. V	Vas an autopsy erformed?	av	ere autopsy findings allable prior to impletion of cause death?	
<u> </u>	The ate h	Ö							1	□Yes 2½ No	1 [	□Yes 2□No	
<u> </u>	sicien: The la certificate hes irector, page 2	B	25. Was case referred to medical examiner?						Death (Check or	nly one)			
5	hysic this c	5	1 Yes 2 No		·	ER/Outpatient		4 LI Nursii	-	Residence 6 🗆 O		(y)	
NOIS!	ding F h. After funer	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigatio		of Injury h, <i>Day Year)</i>	28b. Time of Injury	28c. injui Woi M 1 □	nyat rk? Yes 2∐No	28d. Descri	ibe how injury occi	urred		
2	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not b	e	of Injury - At ho	me, farm, stre	et, factory, office	763 Z 🖂 110	28f. Location	on (Street and Nun	nber or Rura	al Route Number,	
5	s effer	Certification:	4 ☐ Homicide	buildin	ng, etc. (Specify	()	, <b>,, -</b>			Town, State)			
	To the Hospital or Attending Physicien: within 24 hours efter death.  To the Funerel Director: After this certifice completely filled in by the funeral director,	edical (	29a. Certifier (Check only one) 1⊠ Certifying Pr	ysicien: To the l niner: On the ba and mann	sis of examinat	wledge, death ion and/or inve	occurred et the tir estigation, in my c	me, date and p ppinion, death o	ace, and due to	the cause(s) and r ne, date and place	nanner as s e, and due t	tated. the cause(s)	
	To th To th comp	Me	29b. Signature and little of certifier		`		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Yeer)	
)	72		) /V	> M./	7.			978		Apri1	4, 20	08	
_	0		30. Name end address of person who  Nader Tavakoli, N	,			rint) 1e Rd.	Rowie	MD 20	716			
	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signat	h mm		<b></b>		. <b></b>			
	Registra		APR 0 7 2008	· mi	B A	Sil							
DHI	MH 16 Rev 6/95		1.0	·									

amend line 10b per fd aaco hlth dept 0

> **Physicia** /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	03/98 dlw 1 - State Registrar		State of Ma	aryland / [		rtment of H		0000	128	95				
		e (First, Middle, Lasi	t)					2. Date of De	ath					
n.	TOHN F	HENRY SMIT	гн					Month MARCH	29	5:30 7	A M			
r		f not institution, give				4b. City, Town, or	Location of Deatl			c. Counfy of Dea				
	RAVENV	NOOD NURS	ING CENTER			BALT	MORE			N/A				
	5. Social Security N	lumber 6. Se	ex 7. Age	e (In yrs. last bii	rthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year	9. Bir	thplace (State or Fountry)	oreign		
	217-34 Usual Residence of	4-4283	<b>∑</b> M 2□F	73	Yrs.	World 5 Days	TIOUS WIII.	6-28-1			RYLAND			
	10a. State	10b. County Ann	e Arundel	10c. City, Tow							10d. Inside City I			
5	MD.	BALTIN	MORE	GLE	IN B	URNIE					1 <u>X</u> Yes 2	□No		
Directo	10e. Street and Nur	mber				10f. Zip Code			10g. C	itizen of What Co	ountry?			
	GLEN V	VIEW GARDI	ENS APT 1	02		210	51			USA				
l le	11. Marital Status		12. Was Decedent I Armed Forces?		13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No to Rican, etc.)	-	<ol> <li>Race - Ame Black, White</li> </ol>				
7	4.4	ied 2□ Married	1 ☐ Yes 2 🔯 N If Yes, Give	10	1	I∐Yes 21√2 No	Specify:			Specify: BI				
0	3 Widowed	4 ☐ Divorced	Year or Dates:											
Completed by Funeral	(Spec	15. Decedent's Edi cify only highest grad	ucation de completed)	16a	. Deced (Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	16b.   	Kind of Business	/Industry			
ᇤ	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)					DIL	CIZ TIAT TO	M TO ACII	CO		
	-9-	(First, Middle, Last)	-0-		TKA	SH COLLE	18. Mother's Nar	ne (First, Middle			N TRASH			
Re		, , ,	MT TTII					HARRISO		,				
2		E HENRY SI ame/Relationship (7)		104	n Mailin	na Address (Straat				or Town State	Zin Coda)			
			EN (Nepher			lling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Aquahart Rd. Glen Burnie, Md. 21061								
	20a. Method of Disp		or (itepite)	20b. Place of	f Dispo	sition (Name of			ocation - City or					
	1 ☐ Burial 2		Removal from State			natorý or other plac remator		-08	Ba	ltimor	e, Md.			
	21. Signature of Fu	uneral Service Licen	see HARRY RE	ESE	- 1	2. Name and Addre						, P.		
	222 Firth Enter t	the disease or o mr	lications that caused	the death Do	-					LIMD 21-	Approximate			
	shock, or hea	an failure. List only o	one cause on each lin	ie.	.,,,,	Interval Between Onset and Death								
	disease or condition resulting in death)	on —	a. End	Sta	-90	e Ren	al D	Ce	e homic					
		•	Due to (or as	a consequence	Oil									
-	Sequentially list co	onditions,	b. ue ti (Pas	a consequence	5 t	on								
Ē	Cause (Disease or	erlying	11											
Examiner	that initiated events resulting in death)	s Last	Due to (or as	a consequence	of):									
ca			d											
ᇹ														
Completed by Physician/Me	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcome			Je			23d. Date of delivery Month Day Year					
<u>cia</u>	in the past 12 1 ☐ Yes 2 [	? months?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)	/							
hys	9 🗆 Unknown		9 Unknown											
γ	Part II. Other signi	ficant conditions of	ontributing to death b	ut not resulting i	in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of dea	ith?		
D D	Angus	La	LVA	D.	0	Tube	tus	1 🗆	Yes	2 □ No 3 □ F	robably 4 Doni	known		
Set	10		nie Da-P	000	6.			24a. Was		24b. Were a	utopsy findings av	ailable		
Ĕ	- Au		) VEYE	<u></u>				ormed?	death?		se of			
	25. Was case refer	rred to medical					26. Place of De	1  Yes ath (Check only	2.ZN one)	10 1016	5 2112110			
o Be	examiner? 1 ☐ Yes 2 ☑	/	Hospital: 1 ☐ Inpatie	ent 2 ER/O	utpatien	nt 3□ DOA Oth	<del></del>			6 □Other (Sp	acify)			
0 ::	27. Manner of Dear	th	28a. Date of Inju (Month, Da	ry 28b.	Time of			28d. Describe			-97			
<u>s</u>	1 Natural 2 ☐ Accident	5 ☐ Pending investigation		y rear)	Hijury		Yes 2 □ No							
2	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injusting, et	ury - At home, fa	arm, str	eet, factory, office					iural Route Numbe	er,		
Jen I	- LI TOTTICIDE		building, et	o. (openiy)				City of 10	wii, Jia	vn, State)				
Medical Certification:	29a. Certifier (Check only one)		ysician: To the best	f examination a										
Med	29b. Signature and	d title of certifier	and manner st	aleu.		29c. Licens	e number		29d. F	ate signed (Mor	nth, Day, Year)			
-	230. Oigilaturo and	0. 2			2 / 3 : / := 5									

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 17202 3/31/08 HELENA AVEBALTIMORE MD.

SATPALS DANG 31. Date filed (Month, Day, Year) APR 0 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOROTHY ELLEN SHACKELFORD APR.14,2008 12:05P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9300 DANGERFIELD ROAD CLINTON PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Months | Days | Hours | Min. | APR • 22, 1923 | MARYLAND 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 6. Sex **Funeral** 1□ M 2√F 84 Director 577-20-3455 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director MD. PRINCE GEORGE CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9300 DANGERFIELD ROAD 20735 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene important: If item 27 is marked other than "naturar", or items 23a any injury or other traumatic event, the Medical Examinations. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No SpecifyWHITE. 3√2 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) P.G. BOARD OF Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA WORKER EDUCATION 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EMORY FOWLER, SR. MYRTLE M. MOORE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL SHACKELFORD-SON 9300 DANGERFIELD RD. CLINTON, MD. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State | Removal from State | Continuo y State | Continuo 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dulmonare /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has treeter, page 2 s Certification; To Be

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral within 24 hours a To the Funeral I

GI DIE	ea	_ Till Yes 21 No 3 Probably 4 Onkilowii
		24a. Was an autopsy performed? 1
25. Was case referred to medical	26. Place of D	Death (Check only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	g Home 5 Residence 6 □Other (Specify)
27. Manner of Death  1 Natural  2 Accident  2 Accident	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury  M  28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and plaminer: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certified Willay My 29c. License number D0052999 29d. Date signed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10403 HOSPITAL DR. G-06 CLIN RAHIMIAN MDo MD20735

State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 2 1 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician PM von Stocker 815 April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical 5. Social Security Number 6. Sex 7. Age Baltimore Center Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗹 F 216-54-8963 6 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 res 2 □ No MD Funeral Director Talbot ichael 10g. Citizen of What Country? 10e. Street and Number 0 Street Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be U.S permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important; if Item 27 is marked other than any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify <u>م</u> Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Kitchen-Manager 18. Mother Mame (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tot Meclease 41ice 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)

111M: tchell Street Apt. 9 St. M: chaels, MD 19a. Informant's Name/Relationship (Type. Print) Taron Stocker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Charles thomas Memorial 4/11/08 St. Michaels, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee

22. Name and Address of Facility

Hewry Funeral Heme, P. A.

510 Washington St. Cambridge, MD. 2/6/3

Approximate

Shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final Tasma cell leukemia 1 year Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Imonth Sequentially list conditions Examiner Due to for as a passeouring of cause. Enter Underlying Cause (Disease or injury that initiated events Acute Renal failure requires that the death certificate be executed lmonth attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) respiratory and metabolic acidosis ZWecks Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

within 24 hours a

DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Zenithe Pierre

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 South Greene Street, Baltimore, Maryland 21201

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

AU4176435P18292

29d. Date signed (Month, Day, Year)

April 4, 2008

State Registrar JoHa

31. Date filed (Month, Day, Year)

BER

2D08

32. Registrans Signature

FREDERICK MJ-20678

			1 - State of State of Registrar	Maryland / Dep <i>Ce</i>	partment of F ertificate of			ene . №. 2 A A B	12000
4	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	/Medic	al		well	4h Oit Tour	- Lagating of Death	March 29	Day 2008 Year 4c. County of Death	1438 M
	Examir	er	4a. Facility Name (If not institution, give street and nun 520 E. Church Street	iber)	Salisb	r Location of Death ULY		Wicomico	
	Funeral Director		216-06-9776 <sup>1⊠ M 2□ F</sup>	7. Age (In yrs. last birthda) Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry) yland
	yland now at		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or I	Location		<del>, ,</del>	1	10d. Inside City Limits
	ne Mar 8a-f si atified	Director	Maryland Wicomico	Salisb					1 X Yes 2 □ No
	h with the	al Dire	10e. Street and Number 520 E. Church St.		10f. Zip Code 2180	1	10g	. Citizen of What Cour	ıtry?
36	d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	Armed For 1 X Never Married 2 Married 1 X Yes If Yes, Giv	2 Natational	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
2-00	72 hou natura ilical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup	ation during most of workir	16	b. Kind of Business/In	dustry
121	within ene. than " he Mec	Completed	Elementary/Secondary (0-12) College (1	-40r 5+)	ve kind of work done . DO NOT use retired .ional Gua:		i	J.S. Govern	ment.
Maryland 21215-0036	ld be filed withi ental Hygiene. ked other than c event, the M	To Be Co	17. Father's Name (First, Middle, Last)  Donald Craig Sewell	1144	.1001	18. Mother's Name		iden Surname)	
	is 1 and 2 should be for Health and Mental I tem 27 is marked or other traumatic ever	ř	19a. Informant's Name/Relationship (Type. Print)  Janet Wilson/mother					City or Town, State, Zip	
Baltimore,	Pages 1 an ment of Heal ant: If item 2 ury or other		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place of Dispension Cemetery, or Mardela Cemeter	position (Name of rematory or other place Memorial rv	(ce) 4/3/		c. Location - City or To ardela Spr	
Balt	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Hicensee	370	Name and Addre HOLLOWAY 501 Snow	Funeral H Hill Rd.,	Nome Prof	essional A ry, MD 218	association 804
	Physician		23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on eximmediate Cause (Final	aused the death. Do not e ach line.		ng, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  Due to (	or as a consequen of):	2				
		ner	cause, Enter Underlying	or as a consequence of):					
,	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c.	or as a consequence of):					
68760,	cate be physicia the bur	edical	d						
.O. Box 6	aath certif attending for use as	Physician/Me	in the past 12 months?	ant at time of death 5	B⊟Ectopic pregnancy	/		23d. Date of deliver	ery Day Year
S, D	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to to	he cause of death?
or Vital Record	e la has	Completed					24a. Was an autopsy performe 1∐ Yes 2¶	prior to co	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death	(Check only one)		
		n: To	27. Manner of Death 28a. Date of		of 28c. Injur	4 LI Nursing Hon	ne 5 Residence 8d. Describe how	ce 6 Other (Special injury occurred	у)
sion	ending sath. or; Afte	ation	2 Accident investigation 3124		DO M 1	K? Yes 2. Man	hangir	10	
Division	al or Att	Certification:	4 Homicide determined building	of injury - At home, farm, s ng, etc. <i>(Specify)</i> <b>2)} &amp; UMC</b>	street, factory, office	2	8f. Location (Streetly or Town, S		Shew two
	To the Hospital or Attending Physical Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral difference of the function of	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the bar and mann	best of my knowledge, dea asis of examination and/or ner stated.	ath occurred at the til investigation, in my c	me, date and place, a pinion, death occurre	and due to the cau	se(s) and manner as s	tated. o the cause(s)
	To th within To th	Me	29b. Signature and the of certilier		29c. Licens			Date signed (Month,	Day, Year)
	77/1/		30. Name and address of person who completed causi	e of death (Item 23a) (Type	e. Print)	493	5	101100	
	- Qx		Chris Snyder DME 100	e of death (Item 23a) (Type E Corron S! egistrar's Signature	F. Sall	shey n	0 21801		
	Sta Registr	te ar	31. Date filed (MATP Ry, Year) 2008 32	egistrar's Signature	Soule				

DHMH 17 Rev 1/2001

08-02	90	3	
Tonia	v	Swick	

onia Y Swick	State of Maryland /	Department of Certificate of		-	j. No. 2 (1	00 1000
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Ovviale		2. Date of Death	Day Year	3. Time of Death 1346 hrs
1	Tonia Yvonne  4a. Facility Name (if not institution, give street and number)  Cumberland Memorial Hospital	Swick	o. City, Town, or Location of D Cumberland		4c. County of Deat Allegany	h
Funeral Director		(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min.	(MM/DD/YYYY) 9. Bi Forei	
	Usual Residence of Decedent			May 1	, 1909	
faryland 28a-f show any lat once.	MD   10b. County   10b. County   1   1   1   1   1   1   1   1   1	10c. City, Town or Location Cum	nberland			10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f she diffied at once	10e. Street and Number 202 1-E Memorial Avenue		10f. Zip Code 2150		g. Citizen of What Cou	
r death with the or items 23a must be noti	11. Marital Status  1 Never Married 2 X Married Armed Forces?	If Ye	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pu	( Specify Yes or No-		rican Indian, Black,
safter de mral", or i miner mu	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade comp		Yes 2 No specify:	of work done	Specify: Wh	
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 54	+) during mo	ity guard			B. Finan Ctr.
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical To Be Complet	17. Father's Name (First, Middle, Last)  Louis Roger Twigg, Sr.		18.Mother's N	Jame (First, Middle, M Drothy Y. S	aiden Surname)	B. I man ou.
2121; ould be fil d Mental H s marked fite event, To Be	19a. Informant's Name/Relationship (Type, Print )		Address (Street and Number	r or Rural Route Numb	ber, City or Town, Stat	
and 2 sho ealth and tem 27 is traumati	Michael Swick Sr. hus		Race Street	Cu	mberland  20c. Location - City o	MD 21502 r Town, State
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite er	1 X Burial 2 Cremation 3 Removal from Stat 4 Donation 5 Other Specify:	sunset Men		4/18/2008	3 Cumbe	rland MD
Balti permit. Departi Import injury	21. Signar it of Eapera Service Licensus	22. Na	ame and Address of Facility Scarpelli Funer			
Physician /Medical	23a. Part I. Enter the besease, o combications that caused the failure. List only one cause on each line.	_	e mode of Gany, Koll 142 cah	By Ar Bernandae	18 Brock/Volchizant 5U	Approximate Interval Between Onset and Death
taminer	Immediate Cause (Final disease or condition resulting in death)  a Cardiac Arrhy  Due to (or as a consection)	quence of):	D			
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Cardiovascular quence of):	DISease			
cecuted and transit and transit	(Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consected d.	quence of):				
be est	X UNPENDED AMENDED 23a, b	,27 per ME G87	78 5/1/08 amh			
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown  23c. If yes, outcome 1  Live birth 4  Pregnant at ti	2 Fet	al death 3 Ectopic pr er (Specify)	regnancy	23d. Date of delive Month	ery Day Year
s, P.O. B ires that the d signed by the d be detached d by Physical by Physica	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Part I		bacco use contribute t	o the cause of death?
Division of Vital Records, lat or Attending Physician: The law requires is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed				24a. Was a autops	an 24b. Were a	autopsy findings available o completion of cause of
tal Reco	25. Was case referred to medical		26.Place of Death (Cf	1 Yes 2	2 No 1 🗸	Yes 2 No
F Vital   Physician: r this certifi al director, To Be (	TV TES 2 INO	et 2 ER/Outpatient			Residence 6 Oth	er:
ion of itending Pheath. tor: After ithe funeral	27. Manner of Death  1	y 28b. Time of In	jury 28c. Injury at Work?	l.	now injury occurred	
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune-		ury - At home, farm, stree	t, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
To the Hos within 24 h. To the Fun completely	29a. Certifier 1 Certifying Physician: To the best of my one)  2 ✓ Medical Examiner: On the basis of exam and manner stated.					
Me T × T	29b. Signature and title of certifier	//	29c. License number O.C.M.E.		29d. Date signed (M April 14, 2008	fonth, Day,Year)
	30. Name and address of person who completed cause of de Carol Allan, MD Assistant Medical Exam		treet, Baltimore, MD 2	1201	L	
State Registrar	31. Date filed (Month, Day, Year) 32. Registraris	s Signature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day David Stewart Toms April 6 2008 Р /Medical 1:04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 100 West Water Street Smithsburg Washington County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 218-40-2763 65 Yrs. Director April 10,1942 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extent at mast by notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 📉 No Maryland Washington County Smithsburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 100 West Water Street Funeral 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (Ayes 2 1959–1962) If Yes, Give 1959–1962 Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2X No White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Toms ဂ္ Minerva Spangler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Toms -wife 100 West Water St. Smithsburg, MD 21783 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4-10-2008 Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 a 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pancredic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the 1 □Yes 2 □No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? certificate 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ∐ Yes 2 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death. le Funeral Director; A bletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-7+1 Michael McCornock 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#18.PerFHPCC4-7-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PRIL Year **Physician** Ellen Coates Tusch 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/4/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🕏 F Yrs. 218-12-0564 85 Director Hyattsville, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4302 Jefferson St. 20781 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ò Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Ellen Shipley Ellen Shipley Hans L. Coates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 4302 Jefferson St., Hyattsville, MD 20781 Barbara Jean Tusch, Daughter permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 4/5/2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Dasch Janning Gasch's Funeral Home, P.A. 'laudette Hyattsville, MD 2078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demen tu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner preumans As PE NA tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hyperten 100 ~ burial-trar Due to (or as a consequence of): HERRA Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 🗆 Yes 2 🗌 No 2 Accident

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760. attending physician signed by certificate hours after death.

Ineral Director: After this y filled in by the funeral di

with the Maryland

death v

72 hours after

1 and 2 should be

2121 filed within

aryland

Itimore,

To the Hospital within 24 hours a To the Funeral L

ō

29b. Signature and title of certifier m. Brdella, ms

3 Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

18492000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6005 LANDOVER 2D #3, clevery, MD 2078

MUKEMil And ella , mo

32. Registrar's Signatu

State Registrar

Medical

31. Date filed (Month, Day, Year, APR 0 7 2008

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 03

2008

32. Registrar's Signature

	1 - For State Registrar		of Marylan	-	ertificate			mornar 11	Reg. I		100	1 20
	1. Decedent's Name (First, Middle	, Last)						2. Date of D	eath	Day	Year	3. Time of Death
n il	Ali Asghar Vadi							April		2008		5:10am
r	4a. Facility Name (If not institution				4b. City, To	wn, or Loc	ation of Dea	ath		4c. Count	y of Death	
	Shady Grove Adv  5. Social Security Number	entist H	ospital 7. Age (In yrs. I	la et hirthda	Rockv:		Under 24 Hrs	s. 8. Date of B		Monte	gomery	
	449-51-0325	1⊠M 2□F	81	Yrs.			ours Min		ay, Yea		Iran	lace (State or Forei try)
	Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or I	coation						1.	
ō					Location						1	0d. Inside City Lim 1 □ Yes 2按1
Director	Maryland   Montgo	omery	Вой	yds	10f. Zip C	ode			10a (	Citizen of	What Coun	try?
<u></u>	14241 Kings Cro	ecina R1	σ <i>d #/</i> μΩ2		2084							
Funeral	11. Marital Status	12. Was Dec	edent Ever in U.				nic Origin? (	Specify Yes or Nerto Rican, etc.)			State ce - Americ	
	1 ☐ Never Married 2K Marri		2 🔀 No					erto Rican, etc.)			ck, White,	
ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ove Dates:		1 ☐ Yes 2	INO S	pecify:			Speci	かWhit	e
etec	15. Decedent (Specify only highes	s Education t grade completed	)	(Giv	edent's Usual e kind of work	done durin		orkina	16b.	Kind of E	Business/Ind	fustry
Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	`life.	DO NOT use	retired)		· · · · · · · · · · · · · · · ·	_		35.5	• .
3	17. Father's Name (First, Middle, I		5+		Ger	neral	Mother's Na	ame (First, Middle			ın Mil	itary
Re		,					_				me)	
0	Ali Akbar Vadi  19a. Informant's Name/Relationsh			10b Mai	lina Addraga (f			Atefat Rural Route Num			04-4- 7:-	0-4-1
												,
	Shokat Sobhi 20a. Method of Disposition	(Spouse)	20b. P	lace of Dist	osition (Name	of	ssing	B1vd.#4			S,MD - City or To	
	1 ☐ Burial 2 【Cremation		State Co	emetery, cr	ematory or oth	er place)					•	
-	4 □ Donation 5 □ Other (Sp. 21. Signature of Euneral Service I		Met	ropol	itan Cı	emate	ory 4/	3/08 Vol Fun	Ale	exand	ria,	Virginia
	23 f art1. Ent is the shock, or eart failure. List of the shock of eart failure. List of the shock of the sho	_a. pn	caused the death each line. 2000 CM (or as a consequ	ia	nter the mode	of dying, su	uch as cardia	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate	b	(or as a consequ									
	Cause (Disease or injury	Due to	(or as a consequ	ierice or).							-	
Examiner	that initiated events resulting in death) Last	c	(or as a consequ	rence of):					_	_		
2			,	,								
		d										
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live	atcome pf pregna birth 2 □ Fetal nant at time of de nown	death 3	□Ectopic preg □ Other <i>(sp</i> ec						ate of delive onth	ry Day Year
ey P	Part II. Other significant condition	ns contributing to	leath but not resu	Iting in the	underlying cau	se given in	Part I.	23e. Did	tobacc	o use con	tribute to th	e cause of death?
red								10	Yes	2 No	3 ☐ Prob	ably 4 □Unknov
Completed								24a. Wa: auto perl 1∐ Yes		,	prior to cor death?	osy findings availab npletion of cause o
20	25. Was case referred to medical examiner?	Hospital:				Other:	Place of De	eath (Check only	one)			
0 ::	1 ☐ Yes 2 No  27. Manner of Death  Natural 5 ☐ Pending	28a. Date		ER/Outpation 28b. Time Injury		Injury at Work?	I ☐ Nursing	Home 5 ☐ Res 28d. Describe				/)
Sall S	2 Accident investig	ation			М	1 ☐ Yes	2□No					
Cerumcauon.	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned Zee. Plac	e of injury - At hor ling, etc. (Specify		treet, factory, o	office		28f. Location City or To			ber or Rura	l Route Number,
	29a. Certifier 1 Certifying				461 -1			and due to the				
	(Check only one)	<b>Physician:</b> To th Examiner: On the l and mar	e best of my knov pasis of examinat nner stated.	vledge, dea ion and/or i	nvestigation, in	the time, d my opinio	n, death occ	curred at the time	e cause e, date a	e(s) and mand place	anner as st , and due to	ated. the cause(s)
Medical	(Check only 2 Medical E	examiner: On the land man	pasis of examinat nner stated.	vledge, dea ion and/or i	nvestigation, in	the time, do not my opinio	n, death occ ———————————————————————————————————	curred at the time	29d. [	and place Date signe	anner as st , and due to ed (Month, i	o the cause(s)  Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

/N Exa

Fune Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "inatural", or items 23a or 28a-f show

**Physic** /Medi Exami

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alicia T. Mistry 9901 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) APR 0 4 32 Registrar's Signature 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death VO CHAU 1855 MARCH 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL JOHNS HOPKINS BALTIMORE CIT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours 586-48-6386 56 Thailand November 29,1951 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Pennsylvania Allegheny Pittsburgh 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 4245 Parkman Avenue 15213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRCIL, Inc. Billings Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ouv Viet Vo Lan Thi Pham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trang T. Vo - Sister 12612 Tayler Court, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 04/04/2008 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Usensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN TUMOR disease or condition resulting in death) 1 days Due to (or as a consequence of): CEREBRAL HEMOLRIHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a somesquence of

**Physician** /Medical Examiner physician and s the burial-transit certificate be executed Division or Vital Records, P.O. Box 68760, as use

**Physician** 

/Medical

Examiner

Directo

Funeral

ð

Completed

Be

၉

**Funeral** 

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u>

Baltimore, Maryland 21215-0036

death with the Maryland

To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifica completely filled in by the funeral director, p

12

lical Exan	that initiated events resulting in death) Last	cDue to (or as a consected	quence of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregn 1□Live birth 2□Fet 4□Pregnant at time of 6 9□Unknown	al death 3 □Ectop				23d. Date of delivery Month Day Year
by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause	e given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Completed		=				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 No
Be (	25. Was case referred to medical				26. Place of De	ath Check onl one	
고	examiner? 1 ☐ Yes 2 No	Hospital: 1 npatient 2	ER/Outpatient 3	] DOA	Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, of	ice	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
Medical (	29a. Certifier 11 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	rred at thation, in	ne time, date and place my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier			29c. Lic	ense number	29d.	Date signed (Month, Day, Year)

MARCH 31, 2008

600 N. WOLFE ST. BALTIMORE, MIT 21287

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0,0

32 Registrar's Signature

SHREYAS BHAVSAR

2008

04

31. Date filed (Month, Day, Year)

APR

RES-000

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Beath April 3, 2008 Carmilla Wehausen Μ. 12:15 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Healthcare Center Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 14, 1915 Age (In yrs. last birthday 9. Birthplace (State or Foreign 577-07-6138 1 🗆 M 92 Months Days Hours Min. Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Kes 2 □ No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6716 Kipling Parkway 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belintende Joseph Frances Nicastro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgene C. Piazza / Daughter 6716 Kipling Parkway District Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Maryland Vet. Cemetery 4 Donation 04/09/2008 Cheltenham, Maryland neral Service Licensee 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Dequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r 28a-f show notified at

a or ns 23a

"natural", or items dical Examiner m

the Medical

s 1 and 2 should be fill f Health and Mental H ttem 27 is marked ott other traumatic even

permit. Pages 1 Department of H Important: If Iter any Injury or ott

or other t

Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trai attending physician as the nse ξ signed t page 2 this certificate | director. After

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

funeral after death

1 ☐ Yes 2 🖾 I 9 ☐ Unknown			Pregnant at time Unknown	of deat	h 5□(	Other	(spec	ify)				WOTH	Day	real
Part II. Other signific	ant conditions o	ontributir	ng to death but not	t resultin	ng in the und	lerlying	caus	se given in l	Part I.			se contribute to		e of death? 4 Munknown
										per	s an opsy formed? 2 XXVo	prior to death?	completion	ings available of cause of
25. Was case referred examiner?	d to medical							26.	Place of Dea	th (Check only	one)			
1 Yes 2 No	0	Hospital	: 1 ☐ Inpatient	2 🗆 ER/	Outpatient	3□	DOA	Other: 4	XXVursing H	lome 5 ☐ Res	sidence (	6 □Other (Spe	city)	
2 Accident	5 ☐ Pending investigation		. Date of Injury (Month, Day Yea		b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe	e how injur	y occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - A building, etc. (Sp		, farm, stree	t, fact	ory, o	ffice		28f. Location City or To	(Street an own, State	d Number or R	ural Route	Number,
29a. Certifier 1	X Certifying Ph	ysician:	To the best of my	knowle	dge, death o	occurre	ed at	the time, da	ate and place	e, and due to th	e cause(s)	and manner as	stated.	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

6

hin 24 hours a Hospital

within To the

State APR 0 7 Registrar

(Check only

29b. Signature and title of certifier

and manner stated

dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 8:55 April 01 2008 Ruth Grace Wilson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 25612 Coltrane Drive Damascus If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F Yrs May 21, 1927 Pennsylvania 579-30-3161 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Damascus Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 25612 Coltrane Drive 20872 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than "natu matic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Emily Bryant William R. Jones ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ages 1 and 2 st. nt of Health and : If Item 27 is m 25612 Coltrane Drive, Damascus, Maryland Roger Wilson - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Infury or 04/05/2008 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, byly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) NATURAL **Physician** /Medical Due to (or as a consequence of). ATHERD SCLEROTIC HEART Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21X No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate has al director, page 2 death? 1 ☐ Yes 2□ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA ည 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 046747 MD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMARANTH DR, CERMANTOWN MD 19504 TAKHAR ·MANBIR 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

04

2008

APR

1			Registrar					Death				Eliza And And All		UJ
1			1. Decedent's Name (First, Middle	, Last)						2. Date of De			3. Time of De	ath
	nysicia		Clifton Le	on Wilson,	Sr.					Month A O Y 1	Day	7/0/0 g	15:05	M
	Medic xamin		4a. Facility Name (If not institution				4b. City, Town, or	r Location of	of Death	7/1	40.	County of Deat	h	
			1485 Jacob Tom				Port Dep					ecil		
	neral			6. Sex 7. /	Age (In yrs. last birti	hday) (rs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	ıy, Yea <i>r</i> )	Co	hplace (State or Fo untry)	oreign
Dire	ector		214-26-5937 Usual Residence of Decedent		77					Nov. 1	9,193	30   Mar	yland	
/land	at of		10a. State 10b. County		10c. City, Town	or Lo	cation						10d. Inside City L	imits
Mar	ified	to	Maryland Ceci	1	Por	ct 1	Deposit						1 □ Yes 2 <b>]</b>	No
群 2008	e lo	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	untry?	
ath w	ust t	ra	1485 Jacob To			T	2190			16.14		ted Sta		
er de	ner m	nue	<ul><li>11. Marital Status</li><li>1  Never Married 2  Marri</li></ul>	12. Was Deceder Armed Force:	s?	13. V	Vas Decedent of H f Yes, specify Cuba	an, Mexica	igin? (Spo n, Puerto	ecity Yes or No Rican, etc.)	).   '	Black, Whit		
)36 irs aft	xami		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	□NoArmy	1	□Yes ANO	Specify:				Specify: W	hite	
1215-0036 within 72 hours after death with the Maryland ene.	calE	Completed by	15. Decedent	's Education	16a.	Decec	ent's Usual Occup	ation	at of work	ina	16b. Kir	nd of Business/	Industry	
215 thin 7 e	Med	Jple	(Specify only highes Elementary/Secondary (0-12)	College (1-40		life. L	OO NOT use retired	d)	si Oi WOIK	my				
ed wii	t, the	So	9			Me	echanic	10 14-45-	ndo Nome	· /Finak Baintalia		itomoti	ve	
be fill	even	Be	17. Father's Name (First, Middle, I							e (First, Middle,	, ivialiden s	Surname)		
hould d Mei	natic	2	Curtis Ray Wils  19a. Informant's Name/Relationsh		19h	Mailin	g Address (Street			Russell al Boute Numb	er. Citv or	Town, State, 2	Zin Code)	
Ma Id 2 s Iff an	traul		Carol Westerine	1 1 1 1			Jacob Ton				_			1904
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	other		20a. Method of Disposition						Apri			cation - City or		
Page lent o			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from Sta pecify)	te North E Cemeter	asi	sition (Name of natory or other place Methodi	lšt ¦	5, 20		Nort	h East	, Marylar	nd
ati mit.	any Inju	1	21. Signature of Funeral Service		2 '	22	. Name and Addre	ss of Facili	ity Cro	ouch Fui				
<b>a</b> 88 <b>a</b>	P 0	- 0	July 11-6	cel			27 South					East, M	ary1and21	1901
	5		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. Do n line.	ot ent	er the mode of dyir	ng, such as	cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	
Physi		Ì	Immediate Cause (Final disease or condition	_a?	rostate	_	cond	cer	•				years	_
/Med Exam	dical niner		resulting in death)	Due to (or a	as a consequence o	of):								
- 12	251	re e	Sequentially list conditions,	b. Due to (or a	as a consequence o	of):								
nted	unsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events											
exect	rial-tra	Exa	resulting in death) Last	Due to (or	as a consequence o	of):							,	
8760, cate be executed	the burial-transit	dical		d										
c 68	as th	Med	IF FEMALE:											
Box eath cert	for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy	y			2	3d. Date of del	ivery Day Yea	ar
O = 4	hed f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant 9□Unknowr	at time of death	5∟	Other (specify) _							
I Records, P.O. Box 6  The law requires that the death certificate has been signed by the attendings.	should be detached	h Ph	Part II. Other significant condition	ons contributing to death	but not resulting in	the ur	nderlying cause giv	en in Part i	i.	23e. Did t	obacco us	se contribute to	the cause of deat	th?
ds dires	ed bl	d by								150	Yes 2	□ No 3 □ Pi	obably 4 □Unk	nown
Division or Vital Records, if or attending Physician: The law requires the after death.		Completed								24a. Was		24b. Were au	topsy findings ava	ailable
The Is	age 2	omp								auto <sub>l</sub> perfo	psy ormed? 2 No	pnor to death? 1 ☐ Yes	completion of caus 2 □ No	se or
ital	aral director, page 2	BeC	25. Was case referred to medical					26. Place	e of Deat	h (Check only o				
Vision or Vita Attending Physician: r death.	direc	To E	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpa		tpatien		4 LI NI	ursing Ho	ome 5□Resi		Other (Spe	ang liter	. 15
D G	ınera		27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of l (Month, I		ime of njury	Wor			28d. Describe	how injury	y occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 6
SiO tendl leath.	the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r		injury - At home, far	ren etr		Yes 2□	No	28f Location (	Stroot and	d Number or P	ıral Route Numbei	
or At	in by	Certification:	4 ☐ Homicide determ		etc. (Specify)	1111, 5111	set, factory, office			City or Tol			irai noble ivamber	,
spital ours	filled		29a. Certifier 1 Certifyin	g Physician: To the be	st of my knowledge	, death	occurred at the ti	me, date a	nd place,	and due to the	cause(s)	and manner as	stated.	
e Ho	completely filled in by the funeral	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basis and manner		d/or in	vestigation, in my o	opinion, de	ath occur	rred at the time,	date and	place, and due	e to the cause(s)	
Div To the Hospital or A within 24 hours after To the Euneral Direct	comp	M	29b. Signature and title of certifier	/			29c. Licens		,,,			e signed <i>(Mon</i> i		
			M. Ja	Mas, 1	17		1 1	153.	14		ter.	1,20	80	
54	VA		30. Name and address of person		f death (Item 23a) (	Туре,	Print) ice 177	7	R.	1/	it	5. the	ElLTO	5 20 -
911	Sta	•0	H Farks / 31. Date filed (Month, Day, Year)		Son 5 Ho strar's Signature	8	ice 15)	, ,	911	age)	11., 1	4.166	1	1,1

State Registrar

APR 0 4 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician GUY M. WOLCOTT APRIL 2008 12:55P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Montgomery 6001 Muncaster Mill Road-Casey House Rockville If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 M M 2 □ F 56 218-56-9745 Director April 19 1951 Washington, D.C. Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Md. Gaithersburg 1 ☐ Yes 2 No Director Montgomery death with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 7916 Briar Heath Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed ortant: If Item 27 Is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Construction Glazier 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne B. Grogan Charles Ε. Wolcott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 20882 7916 Briar Heath Court, Gaithersburg, Md. Patricia A. Wolcott / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/8/08 Rockville, Md. Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Esophageal Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other:  $4\square$  Nursing Home  $5\square$  Residence 6 MOther (Specify) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

after death. within 24 hours at

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Genevieve Wroblewski,

1355 Piccard Dr., #100, Rockville, Md. 20850

D0064615

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 4, 2008

31. Date filed (Month, Day, Year) State Registrar

3 Suicide

(Check or

29b. Signature and title of certifier

one)

29a. Certifier

Medical

4 Homicide

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

APR 0 7 2008

🛮 🛣 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

29c. License number

P.O. Box 68760, Division or Vital Records,

altimore, Maryland 21215-0036 Certification: or Attending within 24 hours after death To the Funeral Director: in by the To the Hospital completely filled 🗕 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aupanich Rom MD DD065485 -10-2008 30. Name and address of person who compared cause of death (Item 23a) (Type, Print) Barbara Supvich, MD 1500 Forest Glen Rd. Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 22 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death April 18 Day 2008 Year **Physician** 1:32 PM Ronald Dennis Armstrong /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours Min 60 15, Director 472-56-5284 Oct. 1947 Minnesota Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medic I Examination that by notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 5815 Tudor Lane 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Leader for Policy Oversight Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin M. Armstrong Alma F. Magsam ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Jan M. Armstrong/Wife 5815 Tudor Lane, Rockville, MD 20852 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date April 22, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, MD M01346 Rockville, MD 20850 21. Signature of Funeral Service Licens 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bilateral Ventricular Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Post Aortic Valve Replacement 2 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown signed by t t be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) April 18, 2008 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tara Roque, M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 2 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b\_City, Town, or Location of Death Examiner maryland TIMORE 10 Spital eneral 5. Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Under 1 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 1 ■ M 2 📉 F NORTH CAROLINA Director (WAINA KADION) Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 ≥ es 2 No MARILAND Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" — any Injury or other transmitted. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THERADE RIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Mルールルドルにいが Be OE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) ALTO, MD Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSDOUGNE MARYLAND 22. Name and Address of 21. Signature of Funeral Service Licensee JR, FUNERAL HOME CLITON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aklinoma **Physician** /Medical ue to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ascular. The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has death? 2 10 No 1∐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTEND INC DOU 56548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41217 BIZILINNE

State Registrar

300 ARMONL7

Registrar's Signature

SMITE

JLACE

mino

31. Date filed (Month, Day, Year) APR 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician CHOI HUNG AU Ciros AM Apri 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burn
If Under 1 Year If Under 24 Hrs. Medical Center Baltimore Washington Anne Arundel 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 64 218-19-9618 DEC. 9,1943 CHINA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 449 GATEWOOD CT. 21061 or items 23a HONG KONG, CHINA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married カレノ しんり Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced ASIAN Item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) COOK RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 GATEWOOD CT., GLEN BURNIE, MARYLAND 21061 SAU LING AU / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL 23, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State NATIONAL MEM. PARK 2008 FALLS CHURCH, VIRGINIA Donation 5 Other (Specify) ature of Funeral Service Licens e 21. Sig ZZ Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. KIRKLEY-RUDDICK FUNERAL HOM 421 CRAIN HWY. S.E., GLEN BI 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 421 CRAIN HWY. S.E., GLEN BURNIE, MARYLAND 21061 Approximate Interval Between Onset and Death Immediate Cause (Final GACTEOINTESTINAL **Physician** MASCINE HEMORRHACE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HOIDENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day

APR

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of leath (Item 23a) (Type, Brint)

Mognial 32. Regitrar's Signature

DAC149

Zeu Brusue Mi)

death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria as page 2 should be has this Director: After

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** LUCILLE KAREN ALEXANDER Ам 0105 04 16 80 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Markha Days | Hours | Min. | (Month, Day, Ye 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2**X**□ F Months 220-90-9913 4, NOV. MARYLAND Director 1960 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director ALLEGANY MD CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 10100 COUNTRY CLUB ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examine once. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ USA 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEVELOPMENTAL DISABLED Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BARBARA ANN ALEXANDER (RIST) LAWRENCE JOHN ALEXANDER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 LAWRENCE JOHN ALEXANDER 206 RED PUMP RD., BEL AIR, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition **Gardens** 4/19/08 Du Fantey over 1 ey men. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation ↑5 ☐ Other (Specify) Timonium, MD 1050 York Road 22. Name and Address of Facility 21. Signature of Funeral Benyice Towson, MD 21204 Ruck Towson Funeral Home tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause an each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final **Physician** disease or condition resulting in death) 2 WKS oneumonin /Medical Due to (or as a conse ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1ª Inpatient ၉ 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D22181 of death (Item 23a) (Type, Print) 30. Name 😃 0 Bishop Walsh Road, Cumberland, MD 21542 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MERIL 2008 11:40AM Eleanor Patricia Ahearn /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7, 1930 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 78 Director NJ 383-12-1244 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 405 Plumbridge Ct. # 303 21093 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. McHugh Dorothy A. Brickett ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Ahearn/Husband 405 Plumbridge Ct. Unit 303 Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 17. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State Garrison Forest Veterans Cemetery 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service License 2008 Owings Mills, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Lowell M. Lemmon 10 W. Padonia Road Timonium, MD 21093 29a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No cate has page 2 s autopsy perform this certificate 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after uses...

To the Funeral Director: Aft

- Least filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAIL CUNNINGHAM. M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 William H. Baker III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 0 13c iverside cama 05 orien Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Min. Days Hours 1 X M 2 □ F 44 220-82-7462 09-18-1963 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐Yes 2 No Director Jarrettsville Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 USA 4102 Autumn Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) the Me College (1-4or 5+) US Gov't Electronic Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Lana Jordan William H. Baker, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. 4102 Autumn Dr Jarrettsville, MD 21084 Lana M. Baker (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-21-2008 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a contequ Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ∃Yes 2 🗆 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed?
Yes 2 No prior to co death? 1 ∐Yes 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) Be Other: Hospital: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient Certification: To 1 □ Yes / 2 □ NO this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Man or of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accide Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I hours after death.

uneral Director: A
ely filled in by the fu Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide thin 24 hours at the Funeral D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier death (Item 23a) (Type, Print) 100 30. Name and address of person lanue 32. Registrar's Signature State Registrar

12918

		for State Registrar	State of Ma	Ce		of Dea		-	Reg. No.			
		1. Decedent's Name (First, Middle, La	st)					2. Date of De		Year,	3. Time of Dear	
Physici /Medic		JAMES FRANK	LIN BOU	るとこ				APRIL		3000	11:00 F	M
Examir	er	4a. Facility Name (If not institution, give		-		Town, or Locati	on of Death			ty of Death	_	
			DE CIRCLE	(In yrs. last birthday		SSUP	der 24 Hrs.	8. Date of Bir			NIXL	
Funeral Director	Ε.		M 2□F	BH Yrs.		Days Hou	rs Min	(Month, Da	y, Year) 22,1924	VEN	place (State or For ntry) JTWKY	eign
yland sow		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Lir	nits
e Mar la-f st tified	ctor	MD ANNE A	ZUNDEL	JESSU	b						1  Yes 2 □	No
or 28	Dire	10e. Street and Number			10f. Zip (	Code			10g. Citizen of		ntry?	
s 23a	eral	2055 HORSES			9	0744	0110/0		U 5	Ce - Ameri	sen Indian	
72 hours after death with the Maryland natural!" or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent If Armed Forces?  1 Yes 2 1 Yes, Give Year or Dates:	lo	If Yes, speci	ent of Hispanic ify Cuban, Mex No <i>Sp</i> ec		Rican, etc.)		ack, White,	etc.	
72 hou natura lical E	Completed	15. Decedent's E (Specify only highest gr	ducation		edent's Usual	l Occupation k done during r	most of worki	na	16b. Kind of I	Business/Ir	ndustry	
be filed within 72 ho ttal Hygiene. Id other than "natul event, the Medical	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use	e retired)		ng .		naach	CODOTE	
e filed w al Hygie other ti vent, th		17. Father's Name (First, Middle, Last	1	00111	DOIN	ITES N	- ' '	(First Middle	Maiden Surna		FORCES	<u>&gt;</u>
	o Be	Joromo		MILIA				, ,	€ M00			
d 2 should be th and Ments 7 is marked traumatic ev	유	19a. Informant's Name/Relationship			ling Address (				er, City or Towi		p Code)	
and 2 saith ar		JEDNNE BOWL	12/WIFE	20	55 H	00855	SHOF O	CIRCLE	= , 5655	SUA.	MD 20	79
ges 1 and t of Healt if Item 2: or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cri	osition (Name	e of her place)	1	ate	20c. Location	,		
Pages ment of I ant: If Ite ury or o		4 □ Donation 5 □ Other (Speci		ARDENT	CREM	YSTOTY	APRIL	r 32, 208	MARY	shuce	, MD	
permit. Pag Department Important: I any injury o	)3	21. Signature uneral Servic Lice		A	でからて	Address of Fa	012/78	235 ros	HELLEY	Drine	HUMUNTER	iD
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not en	nter the mode	of dying, such	as cardiac o	or respiratory a	rrest,		Approximate Interval Between	1
hysician		Immediate Cause (Final disease or condition resulting in death)	CONGE	STIVE F	EARI	FAI	LURE				Onset and Death	_
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of).	210My	SPAT	44					_
ausit ausit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.									
physician and stransit	Exa	resulting in death) Last		a consequence of):								
g physician and as the burial-transit	edical		_d									
000	-	IF FEMALE:										
been signed by the attendin should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3	□Ectopic pre					ate of deliv Nonth	ery Day Year	
the s	ysic	1 Yes 2 No 9 Unknown	4⊡Pregnant at 9⊡Unknown	time of death 5	Other (spe	эсіту)					,	
ed b)		Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying ca	use given in Pa	art I.	23e. Did 1	tobacco use co	ntribute to	the cause of death	?
n sign Ild be	Completed by	CHRONIC OBSTA	UCTIVE P	ULMONA	py j	DISEASE	£	1 🗆	Yes 2□ No	3 <b>P</b> ro	bably 4 ∐Unkn	own
s beer	lete		•					24a. Was	an 24b	. Were aut	opsy findings avail	able
rate has been signed by the page 2 should be detache	omp								ormed?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause	of
10 0	BeC	25. Was case referred to medical				26. Pi	lace of Death	1 Yes (Check only o	2 No one)	1 🗆 res	2   NO	
	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DO	Other: 4	Nursing Hor	me 5√ Resi	idence 6 🗆 O	ther (Speci	ify)	
fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	y 28b. Time (Year) Injury	of 28	Bc. Injury at Work?		28d. Describe	how injury occu	urred		
eath.	atic	2 Accident investigatio			M	1 ☐ Yes 2	2□No					
s after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injubulding, etc	ry - At home, farm, s c. (Specify)	treet, factory,	office	Í	28f. Location ( City or To	Street and Nun wn, State)	nber or Rui	al Route Number,	
Io the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical (	29a. Certifier (Check only one)	nysiclan: To the best on niner: On the basis of and manner sta	examination and/or i	th occurred a nvestigation,	at the time, date in my opinion,	e and place, death occurr	and due to the ed at the time,	cause(s) and r date and place	manner as	stated. to the cause(s)	
To the within To the comp	Me	29b. Signature and title of certifier				License numb			29d. Date sign			
		monego N	completed cause of de		1	5753	j	/	APRIL:	22,	2008	
( )		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)							
t /		mobil Ness &	601 Vete	yans Hu	y Sull	= 20 y	, mil	Ivsu	illa p	w 2	11:08	
Sta		31. Date filed (Month, Day, Year)	2008 32. Registra	ar's Signature	0				-			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last, 5:25 PM **Physician** Bethea /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner /A Baltimor Date of Birth (Month, Day, Year)
3.30.2008 Birthplace (State or Foreign Country) If Und Under 24 Hrs. 7. Age (In yrs. last birthday) curity Number **Funeral** Months Hours Days 1 □ M 2 □ Director None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Pres 2 No altimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 Walker Avenue Funeral 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Nicole 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 1371 Walker Ave Baltimore, MD 21239 Nicole 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Greenmant Cemetery 4/22/2008 Baltimore City 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of facility Cremation Services 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 Baltimore National Pike Baltimore Mil Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐No 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate l 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of Manner of Death 28c. Injury at Work? Injury Hospital or Attending 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. thours after death. •uneral Director: ₽ ely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Coreene 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State	of Ma	arylan		artment rtificate			and M	lental Hy	/giene Reg. No	_ U L U	12920
			1. Decedent's Name (First, Middle	. Last)								2. Date of D Month	eath Da	av Year	3. Time of Death
	Physicia Medic/		Carol-Sue			Broo	oks					April		2008	10:10 PM
	Examin		4a. Facility Name (If not institution	give street and	i number)			4b. City, 7	Town, or	Location o	of Death		40	County of Dee	th
			4883 Cranston	Court				Wald	lorf					Charles	
	uneral irector		5. Social Security Number 227-78-4422	6. Sex 1 ☐ M 2 📉		e (In yrs. i 55	last birthday Yrs.	Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of B (Month, D Aug. 1	irth Pay, Year, 7, 1	9. Bir 952 Vi	thplace (State or Foreign ountry) rginia
P	-000		Usual Residence of Decedent  10a. State 10b. County			10c Cib	y, Town or L	ocation							10d. Inside City Limits
aryta	shov de	_						ocation							1 ☐ Yes 2 🛣 No
e W	8a-f	Director	Maryland Char	es		Wal	Ldorf	101 7	0-1-				10a C	itizen of What C	ountry?
ith t	or 2	Die	10e. Street and Number					10f. Zip							outily?
ath w	23a	<u>ra</u>	4883 Cranston (						1602		-1-0 (0-			S.A.	arican Indian
ap Je	tems or n	nue	11. Marital Status	Arme	d Forces?		.S. 13.	If Yes, spec	ent of Hi rfy Cuba	n, Mexican	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)	10-	Black, Whi	
1215-0036 within 72 hours after death with the Maryland ene.	ritien "naturel", or liems 23a or 28a-f show the Modical Examiner must be notified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes	es 2 (2). Give or Dates:	NO		1 ☐ Yes 2		Specify:					lack
5-0 72 h	natu	etec	15. Deceden (Specify only higher	's Education it grade comple	ted)		(Giv	edent's Usua b kind of wor	k done d	turing mos	t of work	ing	16b. l	Kind of Business	s/Industry
Maryland 21215-0036 id 2 should be filed within 72 hours after and Mental Hyolene.	other than	ompl	Elementary/Secondary (0-12)	Colle	ge (1-4or	5+)		oo not us acher	e retired	"			Ed	ucation	
G 2 Filled	i i i	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Nam	e (First, Middi	le, Maide	n Sumame)	
ylan ould be	marked	To B	Earl Smith							Gla	dys	Wilson			
aryla should	tem 27 is marke other treumatic		19a. Informant's Name/Relations	hip (Type, Print)	)		19b. Mai	ing Address	(Street	and Numbe	er or Rur	al Route Num	ber, City	or Town, State,	Zip Code)
M 25 E	27 ls		Larry Brook, J:	c. (Son)	)		4883	Crans	ston	Ct.,	Wal	dorf,	MD 2	0602	
s ta			20a. Method of Disposition			20b. P	lace of Disp	osition (Name	ne of ther plac	e)		Date	20c. l	Location - City o	r Town, State
Pages	ry or	li	1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		rom State	Roc	sevel	t Memo	oria	1	4/26	5/08	Ch	esapeak	e, VA
Baltimore, permit. Pages 1 an	Importent: If any injury or gace.		21. Signature of Funeral Service		2,	- 1 a	1 2	2. Name an	d Addres	ss of Facilit	tv			'A 23324	
	12 4 Q		23a. Part . Enter the disease, or		Mu	d the deat	b Do not a	00 Lil	ert	y St.	Che	sapeak or respiratory	e, V	A 23324	Approximate
/M	/sician ledical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	Son each I	e_c	uence of):		-0.0	~~					Interval Between Onset and Death
	aminer -transit	Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G			uence of):								
68760,	attending physician and for use as the burial-transit	cal	,	d											
of Vital Records, P.O. Box 68760, X Physicien: The law requires that the death certificate be executed	y the attending ched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4□F	ive birth	of pregna 2 Feta at time of d	I death 3	□Ectopic pr □ Oth <i>e</i> r ( <i>sp</i>					-	23d. Date of de Month	elivery Day Year
rds, P	n signed by the a uld be detached f	þ	Part II. Other significant conditi	ons contributing	to death l	but not res	ulting in the	underlying c	ause giv	en in Part I	l.		d tobacco		to the cause of death?  Probably
Records, The law requires t	ite has been si bage 2 should l	Completed											topsy	prior to death?	
of Vital	certificate rector, pag	Bec	25. Was case referred to medica examiner?								e of Dea	th (Check only	y one)		
f V	this ce al direc	To E	1 Yes 2 No	Hospital:	1 🗌 Inpat	ent 2	ER/Outpati	ent 3 DC	Oth Oth	er: 4 🗆 Ni	ursing H	ome 59Ae	sidence	6 □Other (Sp	pecify)
On O	n. After th funeral		27. Manner of Deat  1. Natural 5 Pendin 2 Accident investi	ng l	Date of Inj (Month, D	ury ay Year)	28b. Time Injuty		8c. Injur Wor 1 🗆	yat k? Yes 2 □	No	28d. Da crib	e how inj	jury occurred	
Division To the Hospitel or Attending	within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 200.		njury - Al h etc. <i>(Speci</i> l		street, factory	, office		- 0	28f. Location City or 7	(Street a	and Number or I	Aural Route Number,
Hospite	24 hours 9 Funerel etely filler	Medical C	29a. Certifier 1 Certifyin (Check only 2 Medical one)	Examiner: On	o the bes the basis manner s	of examina	owledge, de ation and/or	ath occurred investigation	at the tir , in my o	me, date ai pinion, dea	nd place ath occu	, and due to the time	ne cause e, date a	(s) and manner and place, and di	as stated. ue to the cause(s)
o the	o the	Me	29b. Signature and title of certific					290	c. Licens	e number			29d. [	Date signed (Moi	nth, Day, Year)
) =	ક⊨ ઇ		· KM	002	~			1	66	8	35	7	-	4/21/	08
	8		30. Name and address of person	who completed	cause of	death (Iter	m 23a) (Typ	e, Print)	i	Pla	- k		il	6 Cr	0646
	Sta Regist		31. Date filed (Month, Day, Year	2008	2. Regis	trar's Sign	ature	selle							

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Ε. Blanchard. APRIL 21, Dorothy 11:15 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. Counfy of Death GLEN BURNIE HEALTH & REHABILITATION GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC . 7, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🛛 F Min. 90 217-18-6539 1917 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No Directo GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 NOTTINGHAM DRIVE 21061 UNITED STATES Funeral 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR RETAIL STORES Pages 1 and 2 should be filed inent of Health and Mental Hyginnt: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWIN MOREAU KATHERINE DUNGAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY A. MAURICE/GRANDDAUGHTER 165 CHERRYDELL RD, CATONSVILLE, MARYLAND 21228 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 24, Department of Important: If it any injury or c 1 to Aurial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 2008 BROOKLYN PARK, MARYLANI 4 Donation 5 ☐ Other (Specify) Name and Address of Facility IRKLEY-RUDDICK FUNERAL HOME, P.A. 21 CRAIN HWY., S.E., GLEN BURNIE, eral Servic 0 MARYLAND 2106 23a. Part1. Enter the disease, or complication had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GROWAR YEAT. disease or condition resulting in death) /Medical Due to (or as a consequency of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Box 68760.5 sician a Due to (or as a consequence of): Physician/Medical SS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes STORY HROMBOJIS 2∏No Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 0 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 22, 2008 51104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE JOA 100 strar's Signature

DHMH 17 Bev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 ar **Physician** April 20 7:50 A M William John Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson <u>Gilchrist</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Aug. | 25 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months **½**□ M 2□ F 86 MD Director Aug. 213-14-3858 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f shor must be notified at Phoenix MD Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21131 2414 Stanwick Rd. Funeral death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married other than "natural", or rent, the Medical Evans white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: <u>8</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)
Vice President of a Stevedoring Co. Elementary/Secondary (0-12) College (1-4or 5+) Marine Industry 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Loretta Krepp ဥ John Brown Health and N tem 27 is man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Stanwick Rd., Phoenix, MD 21131 19a. Informant's Name/Relationship (Type. Print) Mary Louise Brown/wife permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once. or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Catonsvile, MD 4/21/08 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Lie Michael Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with Metastases **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto for sels conesqueries of physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Scoul, William Instances, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours a er death To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in examinist. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c\_License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 W. Towsentown 31. Date filed (Month, Day, Year) State 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 8 Month Day **Physician** Elizabeth C. Boyle 04 /Medical Franklin Square
6. Sex County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Koszdale 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 25F 65 214-40-2031 Aug. 18, 1942 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 10a. State 10h County MD Baltimore 1 ☐ Yes 2 No Director Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r items 23a (Iner must b 12117 Buttonwood Lane 21220 USA Be Completed by Funeral Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ Xo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael G. Loring ဥ Edna Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Boyle /husband 12117 Buttonwood Lane Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Figoratric If Ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 4/21/08 Baltimore MD 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave\_Balto. MD 21. Sign ture of shot Connelly Funeral Home of Essex 21221 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Pancre Physician disease or condition resulting in death) /Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Hornicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

IV

Onilosp

APR 2 2 2008

Dr. Larding
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

RES 00000

Drive Ballimore MD 2/239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APIND ITHM/20b, perFH C8/8,4/22/08 WS
State of Maryland / Department of Health and Mental Hygiene
1- State Amend #5, perFH G882 8/21/08 TTCertificate of Death

Reg. No. 2 0 0 Reg. No. 20 Month Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200°C 8 p.M. Thomas Trent Bryant Pril /Medical 4a/Facility Mame (If not institution, give street and pumber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hea imore N/A Social Security Number 217-36-3514 If Under 24 Hrs. 6. Sex 1 M 2 F If Und 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months -36-3514 Hours 68 Director Mar. 14, 1940 Ohio Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4445 Scotia Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No US I If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Examina one. <sup>2</sup>□No US Navy 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Chef United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Edward Bryant ပ Laura Hesler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Bryant - Wife 4445 Scotia Road, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/21/2008 MD vetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State <del>3-21-2008</del>-Crownsville, MD 4 Donation 5 Dother (Specify) @ Crownsville of Funeral Son 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammond Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo cordi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and as the burial-trait Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No r 2 R/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funera Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral C 1 L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVENUE BALTIMORE 21259 13RUTUS SARGINE gistrar's Signatur State Registrar

08-02686 Jesse J. Battle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

esse J. Battle	State of Maryland / Departm	nent of Health and Mental H cate of Death	
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	, ato or boat.	Reg. No. 2. Date of Death 3. Time of Death
ledical Examine	Jusse J. Battle		Month Day Year 1510 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	2110 Haines Street	Baltimore	NA
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign S. + +
Director	214-54-3530 1×M 2 F 58	Yrs.	8-8-1949 Foreign Soth Country Carolina
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
<b>≜</b> .₁	The Bold	bime) Ve -	1 Yes 2 No
Maryland 28a-f show d at once,	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
the Maryland a or 28a-f sh tiffed at once	1113 n. Carrollton Ave	2/2/7	U.S.A.
1 with the Maryland ms 23a or 28a-f sho be notified at once.	10e. Street and Number  1/1/3 \( \hat{N} - \hat{Carroll fon } \)  11. Marital Status  12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ongin? ( S	
or items 23. must be no.	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	
ral", or	3 Widowed 4 Divorced if Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: Black
hours afte "natural"; Examiner		<ul> <li>Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret</li> </ul>	red)
36 in 72 l isal <sup>4</sup> - lical F	Elementary/Secondary (0-12) College (1-4 or 5+)	1.1	Sanitation
5-0036 ed within 72 hour lygiene. tother than "natt he Medical Exat Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	Sanitation  (First, Middle, Maiden Surname)
21215-0036 ald be filed within 7 Mental Hygiene. marked other than e event, the Medica	Arthur Congway	Tessie	Hae Baffle Rural Route Number, City or Town, State, Zip Code)
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  t: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Arthur Cunaway  19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address Street and Number or	Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD pemit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	Jessie Mae Griffin mother	1113 n. Carrollton	Ave. Balk. Ind. 21217 Date 20c. Location - City or Town, State
rre, s l an f Hea If iten	20a. Method of Disposition 20b. Place 20b. Place 20b. Place 20cremation 3 Removal from State	e of Disposition (Name of cemetery, atory or other place)	Date 20c. Location - City of Town, State
Page nent o ant: or oth	4 Donation 5 Other Specify: Greek	nmount Crematory 4-	24-2008 Balto. Nd.
Baltimore, permit. Pages 1 at Department of He Important: If ite	21. Signature of Funeral Service Licensee	22 Name and Addre s f Facility	24-2008 Balto. Nod.  S Funeral ervice 1.4.  Balto. Nod. 21217  Or respiratory arrest shock or heart.  Approximate Interval
	23a. Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dving, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line.		Between Onset and
-xaminer	Immediate Cause (Final disease or condition resulting in death)  a. COCAINE INTOXICATION  Due to (or as a consequence of):	Associated with Cardione	galy
	Sequentially list conditions, b		
ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
o, e be executed sysician and burial - transi	X UNPENDED AMENDED 23a, 27, 28a-f	per ME g878 4/23/08 amh	
76C ficate ficate g phys i the b			23d. Date of delivery ancy Month Day Year
box 6876(). Box 6876() the death certificate by the attending phytherefore to the for use as the both serician/Me	past 12 months?  past 12 months?  4 Pregnant at time of death	Fetal death 3 Ectopic pregr  5 Other (Specify)	indian 52,
Boy death the att	1 Yes 2 No 9 Unknown 9 Unknown		
Records, P.O. Box 6876  The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the frompleted by Physician/M.		ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
S, P			24a. Was an 24b. Were autopsy findings available
Records, The law requirer freate has been sig, page 2 should be			autopsy prior to completion of cause of death?
Rec The la cate h page 2			1 Yes 2 No 1 Yes 2 No
Vital Recysion The bis certificate director, page	25. Was case referred to medical	26.Place of Death (Chec	
5 i s i 5	1 Yes 2 No 1 Inpatient 2 ER	/Outpatient 3 DOA Other Nurs  b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 ✔ Other: Scene
_ = ₹ _ ^ 2   7	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending 7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	1 Yes 2 V No	25d. Sesande nov nga.y occanica
. See 5 5 1 2	2 Accident Investigation Fnd 4/5/08 Fr	nd 3:00p	Ink 28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	3 Suicide 6 X Could not be determined (Specify) Found: In 1		or Town, State) 2110 Haines St., Baltimore,MD
		death occurred at the time, date and place, ar	d due to the cause(s) and manner as stated.
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner:On the basis of examination and/	or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
E S E S	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	hig W. my	O.C.M.E.	April 6, 2008
	30. Name and a ress of person who completed cause of death (Item 23		
\		enn Street, Baltimore, MD 21201	
Stat Registra		Goard.	

State of Maryland / Department of Health and Mental Hygiene 🕦 🗎 🦠 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** MARTIN L. CONAWAY 945 AM 2008 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner TALBOT TALBOT HOSPICE EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15€M 2□F 201-36-6078 60 Yrs MARY LAND Director FEBRUARY 1 1949 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits r than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director DORCHESTEZ EAST NEW AMPLET 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code NEPOT USA 4009 RODD 31631 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Wyes 2 □ No If Yes, Give Year or Dates: V Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) ARCHITECTURE PHOTOGRAPHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fitted Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic eventones, Be MARTIN LAYFIELD COMMAY, SR. MAUDE BROWN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, , ABINGTON, PA 19001 ROSE GRAY/SISTER 1644 EDGE HILL ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANOUER MI ANATOMY LIFTS PELISTA 4/32/08 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

ANATOMY (21FTS)

THE STRY 21. Signature of Funeral Service Licensee HANDUKT MD SIOTH 7532 CONNECTED DRIVE Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. disease Immediate Cause (Final disease or condition resulting in death) End stage renal **Physician** ay S /Medical Due to (or as a consequence of): Examiner abetes type Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ned by the at detached fo 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 No 1 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Specify ٩ 1 ☐ Yes 2 ▼No this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1'⊠Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) څ 4 Homicide within 24 hours a 29a. Cartillar Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) athan MI APRIL DO 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shore Vaidyanathan Health akshmi 32 Registrar's Signature State Congress. Registrar

Physicia	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Ma Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-fs any Injury or other traumatic event, the Medical Examiner must be notified
ır	9000

sician edical miner ral	George Lee Cary  4a. Facility Name (If not institution, g 211 Russe11 Ave  5. Social Security Number 577-26-0493  Usual Residence of Decedent 10a. State 10b. County	give street and numb					Month	Day	3. Time of Death							
ral tor	211 Russell Ave           5. Social Security Number         6           577-26-0493           Usual Residence of Decedent           10a. State         10b. County	., Apt. 22			George Lee Cary  April 20, 2008  1:25 A											
or	577-26-0493  Usual Residence of Decedent 10a. State 10b. County				4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death  Montgomery								
1 H	10a. State 10b. County		Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 2	ay, Year)	9. Birthplace (State or Foreig Country)  Washington, D							
Direc																
<b>-</b>	10e. Street and Number 211 Russell Ave., Apt. 22			. CHELSI	10f. Zip Code	77			What Country?  States							
by Funera	11. Marital Status  1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced	ent Ever in U.S es? □ No	ver in U.S.  13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F				14. Ra Bla	14. Race - American Indian, Black, White, etc.  Specify: White								
Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	7 7 7			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				Kind of Business/Industry							
To Be Co	17. Father's Name (First, Middle, Last)  George Lee Cary, Sr.			ACC	orney	18. Mother's Name	,									
<b> -</b>	19a. Informant's Name/Relationship Katherine M. Car					t and Number or Rui			n, State, Zip Code) burg, MD 20877							
	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Lo															
once.	21. Signature of Funeral Service Licensee  M01346  M01															
ä	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sex venticilly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on each line.  Interval Between Onset and Death Cauche Ca															
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2□Fetal tat time of de	death 3	Ectopic pregnanc	sy		23d. Date of delivery Month Day Yea								
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but the c															
Completed	Ldiopathe	icpul	an o	y Sib.	24a. Was an autopsy performed 1 Yes 2 [			24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No								
ion: To B	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending investigat  2  Accident investigat  3  Suicide 6  Could not determine	be 28e. Place of	njury Day Year)	28b. Time of Injury	t 3 DOA Ott	ther (Specify) irred ober or Rural Route Number,										
	29a. Certifier (Check only one)  1 Certifying 1 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examinati	vledge, death ion and/or in	n occurred at the ti vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) and n	nanner as stated. s, and due to the cause(s)							
	29b. Signature and title of certifier  A. Richard  20 Name and address of parson wh				29c. Licens	se number 94115		1	ed (Month, Day, Year)							
	30. Name and address of person when the Robert Birsch 31. Date filed (Month, Day, Year) APR 22	bach, M.D		Russe	11 Ave.,	Gaithers	burg, M	D 20877								

				State of Ma		d / Dena							•		
		ľ	1 - State Registrar	Oldie of Ivie	ar y lair	•	rtificate			III IVIC	ornar r ry	Reg. No		12928	
10		1. Decedent's Name (First, Middle, Last)  2. Date of Death									,	3. Time of Death			
20	Physicia /Medic											12:15 P M			
	Examin	5	4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or Lo	ocation of	Death	-	4c. County of Death			
	<i>p</i>									nne Aru					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) 1									hplace (State or Foreign buntry)			
30	Director	1	Usual Residence of Decedent		89						Jan. 1	, 19	19 Mar	yland	
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits	
	a-fel	ctor	Maryland Anne Aru	ndel	Lin	thicum								1 ☐ Yes 2 🖾 No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip C	Code				10g. Ci	tizen of What Co	ountry?	
	s 23a	rai	578 Forest View Av				210						ted Sta		
	Item	une	11. Marital Status  1 ☐ Never Married 2 ☼ Married	12. Was Decedent 6 Armed Forces? 1 ☐ Yes 2 ☑ N		.S. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban,	Mexican,	, Puerto R	ity Yes of Nelican, etc.)	0-	14. Race - Ame Black, Whit	e, etc.	
920	urs af	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:			1 ☐ Yes 2 to No Specify:							Specify: Wi	nite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Medical Examinar must be modified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation			dent's Usual kind of work			of workin	7	16b. K	ind of Business	Industry	
7	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use	retired)	,,,g,,,,ost	Or WOTHING	9	D	. • •		
2	lied w tygier her til	S	17. Father's Name (First, Middle, Last)			Bookke	eeper	16	R. Mothor	r'a Nama	(First, Middle	1	tail		
and	d be find be of others	Be	Harry S. Dorney								Thitmo:		i Sumame)		
Maryland	should nd Me mark matter	٩	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (						or Town, State, 2	Zip Code)	
	nd 2 alth al 27 is r trau		Herbert C. Close,	Jr.								-	Maryland		
ore,	of Hear Item		20a. Method of Disposition		20b. F	Place of Dispo				Da	ite		ocation - City or		
Ĕ	Page ment ant: It ury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			tro Cre	emator	y, Ir			008 <sup>21</sup> ,			e, Maryland	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, it a Medical Examination that be notified at once.		21. Signa are of Fune al Service Licen	see		K <sup>22</sup>	Name and	Address o	of Facility	Fune	ral H	ome.	P.A.		
	20 = a		1 M 5/1<1/	/		42	21 Crá	in Hy	wy.,	S.E.	, Glei	ı Bu:	rnie, MI	21061	
	K.		shock, of heart failure. List only one cause on each line.  Interval Between Onset and												
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. My OC	AR,	m	INIF	-na	ZN	UA	1			IHA	
	Examiner		disease or condition resulting in death)  a. My OCAR, M / N FORTON  Due to (or as a consequence of):									20 411			
		Jer	Due to (or as a consequence of):    Cause   Classed   Cl								20 9111				
8	te be executed ysician and e burial-transit	ami													
760,	oe exe	EX													
$\infty$	3	dicai	•	d											
Вок 6	death certificat e attrinding phy of for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy							23d Date of de	livery	
ă	death e atte	iciai	in the past 12 months?  1 Ves 2 No  1 Pregnant at time of death  1 Cive birth 2 Fetal death 3 Ectopic pregnancy  5 Other (specify)							23d. Date of delivery Month Day Year					
P. O.	that the death hed by the attended for	hys	9 Unknown 9 Unknown												
	56 50	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute												
ord	w requir been si should	ted									1 🗆	Yes 2	□No 3□Pi	robably 4 Inknown	
Records,	bas b	Completed									24a. Was	psy	prior to	utopsy findings available completion of cause of	
	ysician: The lav Is certificate has director, page 2										1 Yes	ormed? 2 ☑ No	death?	2 □ No	
Ħ	siciar certif recto	o Be	25. Was case referred to medical examiner?	Hospital:				-			Check only				
ō	Attending Physician: r death. ector: After this certifics by the funeral director, s	$\vdash$	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	у	28b. Time of		c. Injury at	4 🔀 Nur		e 5 ☐ Hes Bd. Describe		6 ☐Other (Spe	icify)	
<u>0</u>	ath. r: Aft	atio	1 1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2						s 2 🗆 N						
Division of Vital	after deat Director:	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At h	ome, farm, str	eet, factory,	office		2	Bf. Location City or To			ural Route Number,	
	Hospital or 24 hours afte Funeral Dir tely filled in	O													
\	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best of liner: On the basis of	examina	wledge, deatl tion and/or in	h occurred at vestigation, ii	t the time, n my opin	date and ion, deat	d place, ai h occurre	nd due to the d at the time	cause(s date an	) and manner as d place, and due	s stated. e to the cause(s)	
)	To the I within 2. To the I complet	Mec	29b. Signature and title of certifie	and manner sta			29c.	License n	number			29d. Da	ite signed (Mont	th, Day, Year)	
	- S - Ö		John She	an,	n.		D	27838	8				il 21, 2		
			30. Name and address of person who o	completed cause of de	eath (Iten	п 23а) (Туре,	Print)					-r -	,		
	10		John Shavers,	M.D., 518	s. c	amp Me	ade Ro	l., L	inth	icum	, Mary	1and	21090		
	Sta	te	31. Date filed (Mogth, Day, Year) APR 2 2 20	08 32 Registra	r's Signa	fure	and a				•				
	Registra	-11	111 11 10 10 20												

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year FREDERICK CLAIR CAAL 41 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hospital Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 5, 1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 72 007-30-2558 Director Maine Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then Z 1s marked other than "nature." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director 1 ☐ Yes 2XXXVo Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 8805 Doves Fly Way Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 2 Yes 2 No If Yes, Give Year or Dates: 1957–96 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Service Agent U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fernand Clair 2 Anita Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Clair/ Son 9516 Shantha Ct., Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 22, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01053

313 Talbott Avenue, Laurel, shock, or heart failure. List only one cause on each line.

M01053

313 Talbott Avenue, Laurel, shock, or heart failure. List only one cause on each line. 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARCANIAL INFARTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2风 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053051 1. Ath. ms 100 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12x1 CDEUM/11. ATHI, MA. CEBAN LAND, WALTER F. 21044 5755 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

Blow & Sperk

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2008 **Physician** Veronica Marie Calk April 16, 6:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. 1920 **Funeral** Months Hours Days 1 □ M 2√2 F 212-18-0316 88 Mar. Mary land Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 28a-f show 1 ☐ Yes 2 ☐ No Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 5550 Oakland Road 21227 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: <u>Ş</u> 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entrepenuer Restuarant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Pacaknowski Veronica Ament ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann Marie Gardner -Daughter 5550 Oakland Road, Halethorpe, MD 21227 Health a Department of Health Important: If Item 27 any Injury or other tronce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Bulial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 4-19-2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd., Arbutus, MD 21227 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final : welt! Physician Virumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstavcitive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 34 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 0 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Peath 5 Pending investigation 1 Natural after death.

Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST Towson no 21204 5 Registrar's Signature State Registrar

# DALSAWIA, MOHRN RAVTI Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Plea	se Type or Pi							egible.		
		1 - State Registrar	State of I	Maryland		rtment of H tificate of L		•	giene Reg. No.	2008	12931	
Physicia	an	1. Decedent's Name (First, Middl			2. Date of De Month	Year	3. Time of Death					
/Medic		Moha	.a			APRIL	- 1 1	2008	2:09 pm			
Examin	er	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or	Location of Death		County of Deat			
8. g.		Doctor's Comm  5. Social Security Number		Ltal Age (In yrs. la	st hirthday)	Lan	ham If Under 24 Hrs.	8. Date of Bir			eorge's hplace (State or Foreign	
Funeral Director			1 M 2 F	78	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Co	intry) India	
Tay Alla		231-49-6294 Usual Residence of Decedent		70				06-15-	1929		illura	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
	ctor	MD Princ	ce George's			Bowie	2				1 ☐ Yes 2X No	
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?	
ath w	rall	13517 Gresham					720			ited St		
er de	Funeral	11. Marital Status	12. Was Decede Armed Force ried 1 Yes 2	es?	5. 13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No o Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>		
s afte	by F	1 ☐ Never Married 2 ☐ Mar 3 🔣 Widowed 4 ☐ Divorced	1	□Yes 2 <b>XX</b> No	Specify:		Specify:					
hour Itural	ed k		Year or Date  nt's Education		16a. Decede	ent's Usual Occupa	ation		16b. Kin	Asian Indian nd of Business/Industry		
in 72 n "na Nedic	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)	25.5.	(Give k life. D	kind of work done o O NOT use retired	during most of wor l)	king			,	
d with giene sr tha the I		Elementary/Secondary (0-12) College (1-4or 5+)  5 Farmer								Farm	ing	
al Hy l othe	Be C	17. Father's Name (First, Middle,		18. Mother's Nam	ne (First, Middle	, Maiden S	Surname)					
Ment Ment arked	Tof	Ravji Dalsar		Purib	en Buta	ni						
2 shc and Is ma		19a. Informant's Name/Relations	and Number or Ru	ıral Route Numb	er, City or	Town, State, 2	Zip Code)					
and leaith m 27 her tr		Pravin Dalsania	a / Son	Look Bl		7 Gresham	Court B					
it of F If Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 ☐Removal from Sta	1 00	metery, crem	sition (Name of natory or other plac	e)	Date	20c. Loc	cation - City or	rown, State	
rt. Pa rtmer rtant; njury	10	4 Donation 5 Other (Specify) W. Arundel Crematory 04-19-2008 Odenton, Maryland  21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1. W. 6.0										
permi Depar Impo any ir		21. Signefule of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A.  1411 Annapolis Road Odenton, Maryland 21113										
		23a. Parti. Enter the disease, o shock, or heart failure. Lis	r complications that cau							Maryiai	Approximate	
Dhusisian	i E liv	shock, or heart failure. List Immediate Cause (Final	t only one cause on eac	h line.	0 L -	1 1	1		VK		Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)		as a conseque	ence of):	Tandar	~e lu	9	126	ف		
Examiner												
E ALEXANDER	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
executed in and ial-transii	Examiner	Cause (Disease or injury that initiated events c										
e exe sian a urial-	_	Due to (or as a consequence of):										
eath certificate be executed attending physician and for use as the burial-transit	dica		d									
ding ge as	/Me	IF FEMALE:	23c If yes outco	me of pregnar	nev					23d. Date of de		
atten for us	cian	in the past 12 months?									Day Year	
the d	ıysi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										
w requires that the dibeen signed by the should be detached	by Pł										the cause of death?	
quire en sig uld ba	q pe			1 🗆	1 ☐ Yes 2 ☐ No 3 🔁 Probably 4 ☐ Unk							
aw re is bee 2 sho	Completed							24a. Was			utopsy findings available	
The I	mo							auto perfo 1⊟ Yes	ormed? 2 DNo	death?	completion of cause of	
ian: rtifica stor, p	Be C	25. Was case referred to medica examiner?	al				26. Place of Dea					
hyslc his ce I direc	To	1 ☐ Yes 2 De No	Hospital: 1 ☒ Inp	atient 2 E	R/Outpatient	3 DOA Othe	er: 4 ☐ Nursing H	ome 5 ☐ Res	idence 6	3 □Other (Spe	cify)	
ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendii	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injur Work		28d. Describe how injury occurred				
tendi leath. tor: A the ft	cati	2 Accident investi	not be				Yes 2 □ No	000 1	(0)			
or At after d Direc in by	Certification:	4 ☐ Homicide determ	nined   Zoe. Flace of	, etc. (Specify,		et, factory, office			wn, State)		ural Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur		29a, Certifier 1 [Y] Certifyi	ng Physician: To the be	est of my know	vledge, death	occurred at the tin	ne, date and place	and due to the	cause(s)	and manner a	s stated.	
e Hos 24 h e Fur letely	Medical		Examiner: On the base and manner	is of examinati								
To the vithin To the comp	Me	29b. Signature and title of certific	er ()	- 1		29c. License	e number	,	29d. Date	e signed (Moni	h, Day, Year)	
			e	> (		1)	4 166	0	(	1-18-	U 8	
2		30. Name and address of person	who completed cause	death (Item		Print)	171	RC	chi	om	Th, Day, Year) C 8  Ze)/6	
)		14300,	CALLA	トノー	te		109	030				
Sta Registr		APR 2	2 2008	istrar's Signat	K do	we						

		For State	State of Ma	aryland	-	rtment of H		Mental H	ygiene Reg. No		12932	
15.36		Registrar  1. Decedent's Name (First, Middle,			2. Date of I	Death		3. Time of Death				
Physici		Garnet C. Edi			April	12.	2008	8:15 A M				
/Medio Examir		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of Dea			County of Death		
	- 37	Brooke Grove Ass	sisted Livir	ıg		Sandy Sp					<del></del>	
Funeral Director		5. Social Security Number 325-12-6264	6. Sex 7. Ag 1 ☐ M 2 🛣 F	e (In yrs. las 96	st birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	(Month.	Birth Day, Year) 6 19	9. Birthp Cour 911 Mont	itry)	
*		Usual Residence of Decedent										
yland		10a. State 10b. County		10c. City,	Town or Loc	ation				1		
e Ma	Director	Maryland Montgo	omery	Sand	ly Spr							
ith th 0r 28	Dire	10e. Street and Number				10f. Zip Code						
ath w	rai	1637 Hickory K	noll Road #4		140.11	2086		Coords Vocas				
lary idfilid Z I Z 1 3-0030 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. is marked other then "naturel", or items 23s or 28s-1 show sumatic event. The Medical Experiment must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 Never Married 2 Married 1 Yes 2 N If Yes, Give			/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	s, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.					
2 hou	ted	15. Decedent	's Education		16a. Deced	ent's Usual Occup	ation during most of w	orkina	16b. K	ind of Business/In	dustry	
Pan 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			life. D	O NOT use retired	d)					
ed wi	Con		2			dminist		ama (First Mide			ing	
d be filly	Be	17. Father's Name (First, Middle, Last) William Henry Crouse						May Ag		2, 2008  4c. County of Death  Montgomery  9. Birthplace (State or Foreign Country), 1911  10d. Inside City Limits 1		
y IC	10	19a. Informant's Name/Relationsh			19h Mailine	Address (Street				or Town, State, Zii	Code)	
MCI d 2 st th and 7 ior		Donna Edison/Da										
Heali		20a. Method of Disposition	augireer	20b. Pla	ce of Dispos	ition (Name of	. [	Date	_			
SAILLIMOR Dermit. Pages Department of mportant: If it any injury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1	-	atory or other place. Cemetery	API.	il 28, 008	Gra	nd Rapids,	Michigan	
DESILITIONE, INICITY ISIN permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service L	II. alene	101173	Rc 75	Name and Addre bert A. P 57 Wiscon	ess of Facility cumphrey Fi sin Avenue	uneral Ho	me, Be	thesda-Che	evy Chase, Inc 814	
8		23a. Part1. Enter the disease, or	complications that cause	d the death.							Approximate Interval Between	
Physician		shock, or heart failure. List Immediate Cause (Final	1, 1								Onset and Death	
/Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
Examiner		Sequentially list conditions b.										
	ner	Transplant of thinnediate Due to (or as a consequence of).										
oute of transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as									
icate be executed physicien and sthe burial-transit		resulting in death) Last										
cate b	dicai		d									
D # D m	Physician/Me	IF FEMALE:	су									
BOX leath cer attendir I for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		Ectopic pregnanc Other (specify) _	у		_	Month	Day Year			
at the de	hysi	9 Unknown	9□ Unknown									
- E B B	by P	Part II. Other significant condition	ons contributing to death t			_	ven in Part I.	23e. D	id tobacco	2008 8:15 A  2008 8:15 A  County of Death  Montgomery  9 Birthplace (State or Foreign Country)  911   10d. Inside City Limits   1   Yes 2 No  itizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry  anufacturing or Town, State, Zip Code)  Maryland 20905  Location - City or Town, State  and Rapids, Michigan  ethesda—Chevy Chase, Incircle Belween Onsel and Death () Approximate Interval Belween () Approx		
COLDS  A require been sig	ed t	CONGESTIVE	HEART	4/41	Sw.	E		_ 1	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
ecor law requ as been 2 should	Completed							24a. V	vas an utopsy	24b. Were aut	opsy findings available	
The law	E							p 1□ Ye	erformed?	death?		
VITAI KECOTGS, sician: The law requires t certificete has been signe rector, page 2 should be	BeC	25. Was case referred to medical examiner?					26. Place of D	eath (Check or	ју оле)			
Of V Physic this ce al direc	To	1 ☐ Yes 25 No	Hospital: 1   Inpati	ent 2□E	R/Outpatien	t 3LI DOA					fy)	
On Oi ding Ph th. : After th		27. Manner of Death 1    ↑ Natural 5 □ Pendin	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	28c. Inju Wo		28d. Descri	be how inj	ury occurred		
SIO tendi eath.	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	gation				]Yes 2 □No	296 Locatio	on /Ctroat	and Number or Du	ral Pauta Mumbar	
Division of all of a ster death.  I Director: After this id in by the funeral d	Certification:	3 Suicide 6 Could not de 4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)				eet, factory, office	ctory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Division of VIta within 24 hours after death.  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Medical (	29a. Certifier (Check onty) one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
omple	<b>⊠</b>	29b. Signature and title of certifier				29c. Licen	se number		29d. D	ate signed (Month	, Day, Year)	
F 5 F 0		180	owe mi			D33	3700		AP	RIL 1Z	2008	
		30. Name and address of person	who completed cause of	death (Item	23а) (Туре,	Print)					704	
10		TED E. HOWE	154 A	1-AR	MSIT	V 9T.	MIL	,IAMST	गटा.	WD C	1175	
200	ate	31. Date filed (Month, Day, Year)		trar's Signati	ure			•				
Regis	trar	APR 22	2008 Mayer	1 15	Spa	Ke .						
DHMH 17 Rev 1/	2001											

State of Maryland / Department of Health and Mental Hygiene 🤈 🗎

3. Time of Death

10d. inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

Year

1 ☐ Yes 2 ☑ No

the Hospital or Attending Physician: 24 hours after death Funeral Director: within 2

> 0 State Registrar

2 2 2008 DHMH 17 Rev 1/2001

31. Date filed (Month

(Check only

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

043515149

08-02928 Pegav Flint Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 12934

gy Filtit		For State Control of The Carth and Mornal For State Certificate of Death		Reg. No.	20	
Physician/	1.	Decedent's Name (First, Middle,Last) Peggy Joan Flint	2. Date of De Month April 14,	ath Day	Year	3. Time of Death 1128 hrs
····.ai Examiner		Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea  1025 Parksley Avenue  Baltimore			County of Dea	th
Funeral Director		Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 M 2 X F  77  Yrs.  If Under 1 Year   If Under 24H  Months   Days   Hours   M	lin.	5/19	DD/YYYY) 9. E	sirthplace (State or Foreig Country) aryland
ow any	10	Sual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimore				10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once	10	Maryland N/A Baltimore  De. Street and Number 10f. Zip Code  1025 Parksley Avenue 21223			en of What Co	ountry?
after death with the Maryland alt, or Items 23a or 28a-f shu iner must be notified at once by Funeral Director		1. Marital Status  Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  Yes 2 X No  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer	Specify Yes or reto Rican, etc.)	No-	White, etc.	erican Indian, Black, White
d sam	:L	B Widowed 4 Divorced of Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	of work done retired)		Specify: (ind of Busines	ss/industry
21215-0036 uld be filed within 72 hour Mental Hygiene marked other than "matu e event, the Medical Exan To Be Completed	1	12 0 Homemaker 7. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle	e, Maiden	Surname)	& Mother
	1	9a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of		lumber, C	ity or Town, St	ate, Zip Code)
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental 1 it: Uitem 27 is marked other traumatic event, To Be	2	Francis C. Flint (Husband) 1025 Parksley Ave.,  Oa. Method of Disposition  Obs. Place of Disposition (Name of cemetery, crematory or other place)  Meadowridge Mem Pk 4/	Date	20c.	Location - City	or Town, State
Baltimore, permit. Pages I at permit. Pages I at I bepartment of Hea I Important: If ite injury or other tr	2	1. Signature of Funeral Service Licensee Revin E ECKer 22 Name and Address of Facility	Funera	1 Hor	ne. P.A	
Physician 'll i al ∡aminer	1	237 F Patansco	ac or respiratory	arrest, sh	ock, or heart	Approximate Inter Between Onset a Death
ed nsit	alliller alliller	b				
and and	ulcai Ex	d.  X UNPENDED AMENDER 2, 27, 28a-f, perME, 8879 5/12/08 I			-	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Faneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transical Coefficial Coeff		F FEMALE:  3b. Was decedent pregnant in the past 12 months?  2c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnant at time of death  4 Pregnant at time of death  5 Other (Specify)		2	3d. Date of deli Month	Day Year
p.O. Bo that the dea ned by the a detached fo	oy Pring	1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Osteoporosis, mitral valve prolapse				e to the cause of death?  Probably 4 Unknov
ords, law requires has been sig 2 should be	Completed	Hyertensive cardiovascular disease	_ p	utopsy erformed	prio deat	
tal Rec	Re Con	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other N		es 2	dence 6 🗸	Yes 2 No
or of Vi ading Physi h. : After this e funeral dir	٥,	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending about 3/23/2008 unk  28a. Date of Injury (Month, Day, Year) about 3/23/2008 unk  28b. Time of Injury 1 Yes 2 √ No	28d. Descr	ibe how in	njury occurred	
Division Hospital or Attend 24 hours after death. Funeral Director: stely filled in by the 1	Certification:	Accident  Nestigation  Suicide  Suicide  Could not be  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locati			or Rural Route Number, (
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	dical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the red at the time,	date and p	olace, and due	to the cause(s)  (Month, Day, Year)
		29b. Signature and tile of dentifier  29c. License number  O.C.M.E.			oril 15, 200	
Outvie	Ì	30. Name and address person to confeted cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore	e, MD 21201	1		
Sta Registra	te	31. Date filed (Month, Day, Year) APR 2 2 2008				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** Rosalyn Grace Fowler 17, 2008 8:25 A™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Catonsville Baltimore 8. Date of Birth (Month, Day, Year) June 18, 1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Maryland 215-12-9825 84 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be nonce. 43 N. Prospect Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Muller ပ Caroline Roos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Hurst, Son 43 N. Prospect Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/18/08 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Cense
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) TO THILLIVE LURE **Physician** /Medical Due to (or as a consequence of): **Examiner** IMER'S DEMENTIA Esquentiarity hat conuments, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: မ 1 ☐ Yes 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Dea 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number Ernander 30. Name and address of person who completed cause of death (Item 23a) (Tipe Print) codo ernando 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

APR 2 2 2008



12936

			1 - For State Registrar	State of N	Maryla	-		nt of Hea		Mental Hy	giene Reg. No.	300		
	Physici		Decedent's Name (First, Middle, Last)     Te	H./						2. Date of De Month	ath Day	Year	3. Time of Death	
•	/Medi Examir		4a. Facility Name (If not institution, give s	1 1	7250	1+21	4b. Cit	y, Town, or Lo	cation of Deat	h		ounty of Death		
	Funeral Director		Social Security Number 6. Sex	era   7. A	Nge (In )\rs 74	s. last birthday) Yrs.	If Und Month		Under 24 Hrs. lours Min.		th V Year)		place (State or Foreign intry)	
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits	
	ith the Maryland or 28a-f show	irecto	MD Worcester  10e. Street and Number		0	cean Ci		ip Code			10g. Citizer	1 Yes 2 10g. Citizen of What Country?		
	iteme 23a o	by Funeral Director	6109 Atlantic Ave.	12. Was Deceden	I Ever in I		Vas Dec	842 edent of Hispa	nic Origin? (S	pecify Yes or No	U.S	Race - Amen		
9036	ours after rai', or ite Examina	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No		_	ecify Cuban, N 2⊠ No S	nexican, Puerl pecify:	to Hican, etc.)	Sp	Black, White, pec <i>ify:</i> <b>whj</b>		
1215-0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f show int, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		r 5+)	(Give	kind of v OO NOT	ual Occupation vork done durin use retired)	n ng most of wor	rking		6b. Kind of Business/Industry		
and 21	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 ie marked other than other traumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)			Secret	aria			me (First, Middle		source,	, Inc.	
laryla	2 should be and Mental I is marked or aumatic eve	To	Edward Huber  19a. Informant's Name/Relationship (Type)	oe, Print)		19b. Mailin	g Addre	ss (Street and		a Brady ural Route Numb				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: if item 27 is eny injury or other tra	(	Mr. Gilbert Fetty  20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Ro		20b.	Place of Dispo cemetery, cren	sition (N natory or	ame of other place)		Unit 20	20c. Locat	tion - City or To		
Baltin	permit. Pa Departme Importent eny injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	e	Ch	m 11558		and Address of	Facility S	ingleton	Fune		le, MD Cremation , MD 21061	
(2)	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart lailure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that cause e cause on each  Due Io (or a	line. Jay	oth. Do not ente	or the mo	ode of dying, si		or respiratory a		,	Approximate Interval Between Onset and Death	
720 130 4/16/2003 68760,	icate be executed physician and sthe burial-transit	dicai Examiner	saventially list conclude if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conse	Small		55-11	scle	ove ch	chae	d	Toly-	
732-04 733 DVD .O. Box 6	the death certify the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fet	al death 3	Ectopic Other (s	pregnancy specify)			23d	. Date of delive Month	ery Day Year	
212  26  rds, P	w requires that been signed by should be deta	þ	Part II. Other significant conditions conf	tributing to death	but not re	sulting in the un	derlying	cause given in	Part I.	23e. Did t			he cause of death?	
al Reco	The la ate has page 2	Completed					_			24a. Was autop perto 1 Yes	rmed?	4b. Were auto prior to cor death? 1 ☐ Yes	opsy lindings available impletion of cause of	
Pet De B Vital	sicial certi	To Be	25. Was case referred to medical examiner?  1 Yes SUNO	ospital:	iont Of	] ER/Outpatient	ه ا	Other		th Check only o				
7			27. Manner of Death	28a. Date of Inj	ury	28b. Time of	30 6	28c. Injury at Work?	☐ Nursing H	ome 5 Resident			V)	
Pary Division	f or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certification;	t	(Month, Di 28e. Place of Ir building, e		Injury nome, larm, stre	M et, facto	1 🗆 Yes	2 🗆 No	281. Location (5	Street and N	lumber or Aura	al Route Number,	
Mary	To the Hospital or A within 24 hours after To the Funeral Direction bis completely (illed in by		29a. Certifier To Certifying Physi	cien: To the besi	t of my kn	owledge, death	occurre	d at the time. d	ate and place	City or Tow	cause(s) and	d manner as st	taled.	
	the H nin 24 the Ft	Medicai	one) 2 Medical Exemin	er: On the basis of and manner s	of examina	ation and/or inv	estigatio	n, in my opinio	n, death occu	rred at the time,	date and pla	ice, and due to	) the cause(s)	
	To To	2	20b. Signature and title of partitles	$\sim m^{\circ}$	)		29	06461	mber 15		29d. Date si	gned (Month,	Day, Year)	
	5	1	30. Name and address of person who con	npleted cause of	death (Ite	m 23a) (Type, F	Print)	Drive	Be Be	71N N	10 2	21811		
	Sta Registra	te ar	31. Date liled (Month, Day, Year)  APR 2 2 200	8 32 Regist	rar's Sign	to for	de							

State of Maryland / Department of Health and Mental Hygiene ) 1 9

3	0	0	2	-
1	E.	7	0	-

			1 - For State Registrar		, racing	Ce	rtificate of L	Death	F	Reg. No.	UUO	2001	
	Physicia	an	1. Decedent's Name (First, Mide			2011			2. Date of Dea Month	Day	Year	3. Time of Death	
	/Medic		NANCY	ANNE	For	CD Y I			APR		2008	8:30AM	
	Examin	er	4a. Facility Name (If not instituti								inty of Death		
	1000	to.	Howard County				Columbia		To Date of Bird	Howa		- CO 1	
b	Funeral Director		5. Social Security Number 215-30-4666	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. la	71 Yrs.	If Under 1 Year Months Days	Hours Min.		v, Year)	9. Birthp Coun	lace (State or Foreign htry) MD	
	pu. »		Usual Residence of Decedent  10a. State 10b. Count		10c City	, Town or Lo	ocation				1	0d. Inside City Limits	
	larylan show ed at	'n										1 ☐ Yes 2 ☑ No	
	he M 18a-f otifie	Director	MD Howar	α	Jess	sup	105 7in Code			10a Citizen	of What Cour	ntru?	
	with t		10e. Street and Number 9964 Guilford	Poad			10f. Zip Code 20794				DSA		
	sath	era		12, Was Decede	ant Ever in U.S	3 13	Was Decedent of H	isnanic Origin? (9	Snecify Yes or No-	1	Race - Americ	an Indian,	
9	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examin.r must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed Force	es? X⊓No		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ın, M <i>e</i> xican, Pue	to Rican, etc.)	F	Black, Whit <i>e</i> , <sub>ecify:</sub> whi		
03	ours ral",	d by	3 ☐ Widowed 4 ☐ NDivorce	Year or Date	es:		TELICS ZAETEO	opeony.		and the co			
21215-0036	72 h	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	-	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind o	of Business/Inc	dustry	
121	within iene. than "	ш	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NOT use retired</i> nistrative		I	Cl o	rical		
2	filed w Hygie hther ti		17. Father's Name (First, Middle	2 ( act)		Admili	IISCIACIVE		me (First, Middle,				
anc		Be	Earl Kriete						Ruth Kane		name)		
ž	should be ind Menta marked umatic ev	To	19a. Informant's Name/Relation			10h Maili	ng Address (Street				un Stata Zir	Cadal	
, Maryland	12 ha 7 is		Tracey Rollins			29490	Kingstor		Westover	, MD 2	1871		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Removal from St	1 00	ace of Dispo emetery, cre	osition (Name of matory or other plac	e) Apr	il 21,	20c. Location	on - City or To	own, State	
Ĕ	permit. Pages Department of I Important: If its any injury or or once.		4 □ Donation 5 □ Other		Wes		ındel Crem	20	08		on, MD		
alt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service	e Licensee		2	2. Name and Addres	ss of Facility De	onaldson	Funer	al Hom	e,P.A.	
_	9 7 E # 9		Then Hit		01053		13 Talbot				20707		
d			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that cau st only one cause on eac	ised the death th line.	. Do not en	ter the mode of dyin	ig, such as cardia	ac or respiratory as	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	RE	SPIR	ATO	RY FA	TILUM	RE		1	Onset and Death	
	/Medical		resulting in death)	Due to (or	as a consequ	ence of):	PNEU						
3	Examiner		Secure finity list conditions				PNEU	MONI	AJEM	IP YE	MA		
7	p tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ	ience of):							
	rtificate be executed ng physician and as the burial-transit	аш	that initiated events resulting in death) Last	C	E4S	ionco of):							
60,	oe ex cian a	_	,	,		,	UER						
68760,	cate b	Medical		d	<del></del>								
			IF FEMALE:	23c. If yes, outco	me of pregna	ncv				004	Data of dallin		
Box	eath cer attendir for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ∐ Fetal nt at tim <i>e</i> of de	death 3	⊒Ectopic pregnancy □ Other (specify)	/		230.	. Date of delive Month	ery Day Year	
	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/	1 ☐ Y <i>e</i> s 21☐ No 9 ☐ Unknown	9☐Unknov		eam 5	Other (specify)						
P.0	that ted by		Part II. Other significant cond	itions contributing to dea	th but not resu	ilting in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?	
Vital Records,	uires tha signed I d be det	d by	SUPRA	VENTRIC	MLAT	e :	TACHYC	ARDA	1 0	Yes 2□N	lo 3□ Prol	bably 4 Unknown	
Ö	w require been sig should b	Completed							24a. Was	an 2	Ah Wara aut	opsy findings available	
Rec	ne lav has ge 2:	ш							auto		prior to co death?	empletion of cause of	
a			05.18						1□ Yes	2. No	1 ☐ Yes	No	
Ĭ	Physician; r this certificanal director,	Be	25. Was case referred to medic examiner?	Hospital:		ED/O	nt 3DDOA Oth	or:	eath Check onl		Tou 10		
ō	Phys rathis raldi	-T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		28b, Time	III JU DON	4 🗀 Nursing	Home 5 ☐ Resi			fy)	
o	Attending F r death. ector: After by the funer.	io	Natural 5 ☐ Pend	/A Annth	, Day Year)	Injury	of 28c. Injur Wor M 1⊟	k? Yes 2 □ No		,			
Si	death death ctor:	icat	3 Suicide 6 □Coul	d not be	f iniurv - At ho	me, farm, si	treet, factory, office		28f, Location (	Street and N	umber or Rur	al Route Number,	
Division	or A after Direction by	Certification:	4 ☐ Homicide dete		g, etc. (Specify		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To				
	spital ours a leral filled		29a. Certifier	ying Physician: To the b	est of my know	wledge, dea	th occurred at the ti	me, date and pla	ce, and due to the	cause(s) an	d manner as	stated.	
	24 hi	Medical	(Check only 2 Medic one)	al Examiner: On the bas and manne	sis of examinat	tion and/or i	nvestigation, in my o	opinion, death oc	curred at the time,	date and pla	ace, and due t	to the cause(s)	
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certi	fier			29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)	
	⊬ × ⊢ ŏ		) Show	s. Calos	m		DO	0642.	20	API	7. 20	, 2008	
	/		30. Name and address of person			23a) (Tvno						2008	
4	5		JUAN H. CARI	RERAS M.D	575	S CE	DAR L	ANE.	COLUMR	IA.	HD 3	21044	
	Sta	te	31. Date filed (Month, Day, Yea	ar) A2. Re	gistrar's Signa	ture			. , ,	-	-		
	Registi		31. Date filed (Month, Day, Yea	2008	יל גע	400	W.						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup> 2008 Year April 18, Donald Theodore Armacost Fair, Sr. 5:25 A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. XXM 2□ F 86 20,1921 215-09-1041 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Nightingale Way Apt B-2 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes XXNo White If Yes, Give WWII Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Attorney Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Theodore Fair Daisy Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Fair Wife 12 Nightingale Way Apt B-2 Lutherville, Md21093 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Abrahams Cemetery 4/26/2008 4 Donation 5 Dother (Specify) Beckleysville, MD 21. Signature of Frineral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final State disease or condition resulting in death) nd Due to (or as a consequence of): ypor Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an performe 1 □ Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner The law requires that the death certificate be executed Exami

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

ဂ္

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the fredical Examination that be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Its Max

death v

72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the buriat-tran detached signed is be deta page

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

certificate After this certific funeral director, death.

Ī	ā	Ĭ
I	.2	ı
I	S	1
Į	$\geq$	ı
l	立	
ı	<u>ک</u>	
ı	7	
l	ě	
ĺ	e	1
ı	ם	î
ı	Ε	
ı	Ö	
ı	O	ŀ
l	Be	
ı	~	

Certification: To

Medical

29a. Certifie

/Medical

or 24 hours after death.

Be Funeral Director: A bletely filled in by the fu

9 LI Unknown		
art II. Other significant conditi	ons contributing to death but	not resulti
Deri Mund	S/ASCULLON	150

examiner?							, , ,		- 5 /	-
1 Yes 2 1	Ñο	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3□	DOA Other: 4	4 ☐ Nursing H	ome 5 ☐ Residence	6 ☐ Other (Specify)	17	020
27. Manner of Death 1 ☑ Natural 2 □ Accident	5 ☐ Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how inju			
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street	t, facto	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Fi te)	oute	Number,

3 ☐ Suicide determined 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (s)

(Check only one)		on and/or investigation, in my opinion, death occurred at t	
29h Signature and	title of certifier	29c. License number	29d Date signed (Month Day Year)

D25205 April 18,2008 N. Choules St. Balto. Md 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

completely

within 2 To the

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / State of Maryland /	Department of Certificate of			jiene <sub>leg. No.</sub> 2001	8 12939	
	Physici	ian	Decedent's Name (First, Middle, Last)     Dora Fowlkes			2. Date of Deat Month	Day Yea	LA.	
-	/Medio		4a. Facility Name (If not institution, give street and number)		n, or Location of Death	04	17 2008 4c. County of De	5:57 A W	
4			Gilchrist Nursing Home		altimore				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 10 M 200x) 7. Age (In yrs. last to 10 M 200x)	birthday) If Under 1 Ye.  Months Day		8. Date of Birth (Month, Day, Oct. 7, 1	; Year) (	irthplace (State or Foreign Country) VA	
	D		Usual Residence of Decedent  10a, State 10b, County 10c, City, To	wn or Location		1000. 79 1	10d. Inside City Limits		
	Maryla -f sho	to	MD	Baltimore				1  Yes 2  No	
	th the	Director	10e. Street and Number	10f. Zip Cod		1	0g. Citizen of What 0		
	sath wise 23a	eral	421 East 21st Street	40.14	21218			JSA	
036	be filed within 72 hours after death with the Maryland tial Hyglene. od other than "natural", or tiems 23a or 28a-f show event, the Medical Evan har met by nothing at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  **Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Wes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S tuban, Mexican, Puert No <i>Specify:</i>	pecity Yes or No- o Rican, etc.)	fy Yes or No- can, etc.)  14. Race - American Indian, Black, White, etc.  Specify: African  American		
15-0	"natur	letec	15. Decedent's Education (Specify only highest grade completed)	king	16b. Kind of Busines				
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work do life. DO NOT use ret housekeep					
Baltimore, Maryland 21215-0036	2 should be filed vand Mental Hygin is marked other aumatic event, It	To Be C	17. Father's Name (First, Middle, Last)  Truly Knight			ne (First, Middle, M 7rtle Ferge			
Mar	ーチトト		9	9b. Mailing Address (Stre				, Zip Code)	
ē,	Heal		Barbara Joyner / Daughter  20a. Method of Disposition 20b. Place	3847 Lynda1 A of Disposition (Name of tery, crematory or other p			21213 20c. Location - City of	or Town, State	
imo			12 Abunal 2 Li Cremation 3 Li Removal from State	tery, crematory or other p ood Cemetery	04/22/	/ <sub>2008</sub>	Baltimore, Ma	arvland	
3alti	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Ad	dress of Facility Why	vlie Funera	1 Home, P.A.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do		nor Street; I			Approximate Interval Between	
	Physician pe executed // // // // // // // // // // // // //	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Line Indepting Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence cause. Line Indepting Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence cause. Line Indepting Cause (Disease or injury that initiated events resulting in death) Last	e of):	er			Onset and Death	
	that the death certificated by the attending poor detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown				23d. Date of d Month	elivery Day Year	
ds, P.	es iigh	þ	Part il. Other significant conditions contributing to death but not resulting	in the underlying cause	given in Part I.			to the cause of death?  Probably 4 ☐ Unknown	
	70 CD CV	Completed				24a. Was ar autops perforn 1 □ Yes 2	y prior to ned? death?	autopsy findings available completion of cause of	
Z Z	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ EB/C		Other:	th (Check only one	. 4		
on of	ding Phys th. After this funeral dir	tion: To	1 Inpatient 2 ER/C	. Time of lnjury 28c. In	4 □ Nursing H njury at /ork? □Yes 2 □ No	ome 5 ☐ Reside 28d. Describe ho	ence 6 <b>X</b> Other (Sp ow injury occurred	pecify) WOSFLU	
Divis	to the thoustal or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)			28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,	
:	Hospi 24 hour Funera stely fills	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge and manner stated and manner stated	ge, death occurred at the and/or investigation, in m	time, date and place by opinion, death occu	, and due to the corred at the time, do	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)	
:	Vithin to the To the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. Lice	ense number	29	9d. Date signed (Mor	nth, Day, Year)	
	,		> Ghalm	9	58303	1	APRIL 17	2008	
	h		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	once si	- This	ovno	217 071	
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Costs	-1-03 01		4, 4 . 0.7	7	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2940 State of Maryland / Department of Health and Mental Hygiene | | | | | | 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** GUGL11221 : 30 AM ĎЧ /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Parkville Balto.Co. 9766 Deltom Court Year If Under 24 Hrs. 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**□M 2□F Min Months Days Hours 69 216-36-2495 Yrs Director 1-6-1939 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Exemples must be notified at 1 ☐ Yes 2 No Director Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 9766 Deltom Court 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏚 ☐ No Specify: Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. 7 Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) Construction Co 12th Owner traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Zagroba Carlo F. Gugliuzza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Germaine C. Gugliuzza 9766 Deltom Court Parkville,Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Depertment of Important: If its sny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-21-2008 Parkwood Balto.Md. 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit ed by the attending physicien and detached for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown : certificate has been signed by t irector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funeral Director: , completaly filled in by the t 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Typertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

State

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

23a) (Type, Print) 5601 LOCH RAVEN BLUD

0466/422A

Vital Records,

o

Division

DHMH 17 Rev 1/2001

Registrar

APR 2 2 2008

Baltimore,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death **Physician** 8 2008 /Medical ty Name (If not institution, give street and number) Examiner N/A 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral №** М 2 🗆 F Director 215-09-9814 94 5/18/1913 MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Directo MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be 7925 YORK ROAD USA 14. Race - American Indian, APT. 115 Funeral 21204 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ ¾XWidowed 4 □ Divorced WHITE Completed ti of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YEARS SUPERVISOR TELEPHONE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည ANTHONY A. GRABUS ELIZABETH C. SCHNEIDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KATHIE IMHOFF/DAUGHTER YORK, PA 933 STREAM VIEW LANE A 17403 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial / 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donay on 5 ☐ Other (Specify) PARKWOOD CEMETERY 4/22/2008 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Sign/tur of Funeral Service Linnsee 8521 LOCH RAVEN BLVD. TOWSON. MD Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nysician Renal Failure Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): Physician/Medical as the attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 2 No 1∐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records. P.O. Box 68760. the

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 2 2 2008

Cass and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

6565 North Charles

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0006 1199

29d. Date signed (Month, Day, Year) April 18, 2008

St, Suite 209, Touson MD 21204

		1 - For State Of Registrar	iviaryianu		rtificate of L			eg. No.2 O C	8	12943
Physi	cian	1. Decedent's Name (First, Middle, Last)					Date of Deat Month	Day \	'ear	3. Time of Death
/Me	dical	Helen E. German	f \		4b. City, Town, or	Location of Dogth	April	20 20 4c. County of	08	8:55PM
' Exan	niner	4a. Facility Name (If not institution, give street and num  St Agnes Hospil	3	İ	Ba	h mor	e		N/A	
Funera			7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 9,	1925	Birthpla Count Mar	ace (State or Foreign yland
pu ,		Usual Residence of Decedent	100 City	Town or Lo	cation				10	d. Inside City Limits
laryla shov	<u> </u>	Maryland Howard								1 □ Yes 2 No
the N 28a-f notifie	rect	10e. Street and Number		ETTIC	10f. Zip Code		10	0g. Citizen of Wh	at Count	ry?
3a or	Ë	2713 Brinkleigh Drive			210	42		USA	A	
OTE, INISTYISTIC ZIZIO-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hyglene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?		Was Decedent of His If Yes, specify Cuba 1 ☐ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e	tc.
5-0036 72 hours af natural", or dical Exam	2						1			
n 72 h "nati	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation luring most of work )	ing	16b. Kind of Bus	ness/ind	ustry
within lene.	٤	Elementary/Secondary (0-12) College (1-	4or 5+)		counting			Hos	pita	1
e filed al Hygi other	B G					18. Mother's Name	e (First, Middle, I	/laiden Surname	)	
Iaryiano 2 should be f and Mental b Is marked of aumatic eve	Ļ	Guy Longan					garet So			
Tary 2 sho and 1s ma	1	19a. Informant's Name/Relationship (Type. Print)	ŀ		ng Address (Street a					,
e, IV 1 and Health em 27 ther tr		Paul C. German, Son	20b. Pla			~		20c. Location - C		1and 21042
Pages nent of hant: If ite		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from S	itate i		esition (Name of matory or other place ematory In	1			•	
□ → 1 1 1 1 7 7	es.	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Serviced icensee	Metr					Baltimor		
Dep Dep any	ouce	21. Signature of Funeral Serviced icensee Thomas Gregor		}	Name and Address remation 199 Freder	Society rick Road	Baltimo	re, Mar	c y1an	d 21228
Physicia /Medica		23a. Part1. Enter the disease, or complications that consider the shock, or heart failure. List only one cause on earlier disease or condition resulting in death)		Myo	er the mode of dying			est,		Approximate Interval Between Onset and Death
ificate be executed  physician and st the burial-transit	odical Evaminar	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (c. Due to	or as a conseque	ince of):	Υ				2	years
death cert death cert a attending d for use	Dhveician/Mc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	come pf pregnand irth 2  Fetal d ant at time of dea wn	teath 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date Mon		ry Day Year
ords, F.C requires that the een signed by the rould be detache	hy Dh	Fait II. Other significant conditions contributing to de		ing in the u	nderlying cause give	en in Part I.	23e. Did to	pacco use contril	ute to th	e cause of death?
quire:			der				1 🗆 Y	es 2 No :	Prob	ably 4 □ Unknown
The lar	Completed						24a. Was a autops perfort 1∐ Yes	med?	ath?	osy findings available inpletion of cause of
VITAI ician: T certificat ector, pa	Ro	25. Was case referred to medical			To:	26. Place of Deal	h (Check only or	e)		
Of N Physic rthis c ral dire	Ę	1 Yes 2 No	npatient 2 E	R/Outpatier 28b. Time o		4 Li Nursing H	ome 5 Reside	ence 6 Other	. , . ,	)
ding F	<u>.</u>	27. Manner of Death  1 Natural 5 Pending (Mont	h, Day Year)	Injury	Worl	yat <br Yes 2□No	Zou. Describe n	ow injury occurre	u	
IVISION  or Attending after death.  Director. After on by the fune	Cortification.	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place building	of injury - At hom ng, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	r or Rura	l Route Number,
LIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifica completely filled in by the funeral director, is	Cleviba	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the band mann	asis of examination							
To the To the To the Comple	Mo	29b. Signature and title of certifier			29c. Licenso			9d. Date signed		
		> Soddy Weeray				0965		April 1.	20,	2008
10		30. Name and address of person who completed dus NEERAJA BODDU ST	e of death (Item 2	23a) (Type,	Print)	005 CATO	NAVEN	WE, BY	117	MORE, MD
	State	31. Date filed (Month, Day, Year)	egistrar's Signatu	ire	111101		., -,	/		

DHMH 17 Rev 1/2001

State

Registrar

APR 2 2 2008

German, Helen

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2008 **Physician** 0630 M Graleski imond /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Harber Hospital 1+ more 7. Age (In yrs. last birthday 73 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 219-28-4015 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Examiner must be notifled Director Anne Arundel MD Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6231 Groveland Road 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aerospace 4 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Kotowski Matthew James Graleski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other training. 6231 Groveland Road Linthicum, MD 21090 Mrs. Gloria L. Graleski/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee MU/357 Services 1 2nd Avenue SW Glen Burnie, MD 21061 ancera 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or recardiallure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Coronai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 TER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director; / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 4/15/2008 29b. Signature and title of certifie 464990

State

31. Date filed (Month, Day, Yea

, DO 3001 S. Hanover-St. Baltimore, MD 21225
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Scheraga, DO 3601 S. Ite

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ROHAN

MEMORIAL

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

2008

APRIL 16

and manner stated.

UNION

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOFFATTI

2 2 2008

State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:10 AM W22 2008 8 /Medical .aa pril 4a. Facility Name (If not institution) give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Year **Funeral** 1 M 2 M F Days Director Baltimore, UN 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 No Director HOINGDO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip code 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: 21009 1 anc 2 should be filed within 72 hours after death v Healt, and Mental Hygiene. em 2' is marked other than "natural", or items 23s Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 Divorced nit Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Ke or other raumatic event Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other ra heresa MD 20b. Place of Disposition (Name cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation Harford Memorial Gordens 4 Donation 5 Dother (Specify) berdeen 22. Name and Address of Facility 21. Signature of Funeral Service Ocensee Forest Hill, MD 21050. Bai Evans Fuered Chapel + Cumation Societs-BelAir. kal e, compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on ea fyline. 23a. Part1. Enter the dise shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Deptic 3 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☒No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No a 24a. Was an certificate has autopsy performed? 2 100 actic aL C 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 24 No Certification: To 1 npatient 2 ER/Outpatient 3□ DOA Sid. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053568 18 2008 pril 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PSON . Registrar's Signature 31. Date Hed (APR 2 2 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Shaundretta Evon Griffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 12947

		1- For State Certifica	ate of	f Death			F	Reg. No.		
Physicia		Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
/ledical Exami		Shaundretta Evon Griffin					Month April 14,	Day Yea 2008	ır.	1046 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Tow	n, or Loc	ation of De		4c. County	of Death	
		Johns Hopkins Hospital		Baltimo	re					
						f Under 24	IUro I O Data of B	irth(MM/DD/YYYY	N O Die	hplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	iday)	If Under 1 Months			Min.	itti (MM/DD/TTTT	Foreign	n
Director		212-41-4746 <sub>1 M 2</sub> XXF 14	Yrs		Days	Tiours	Nov. 24	, 1993	Cou	antry) MD
		Usual Residence of Decedent								
any		10a. State 10b. County 10c. City, Town of	or Locat	tion						10d. Inside City Limits
8	. 1	MD		Baltin	ore					1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	40° Chrost and Number		106 7in Co	do			10g. Citizen of Wi	hat Cour	atru/2
Mar. 289	ě	10e. Street and Number 1930 McCulloh Street		10f. Zip Co		217		Tog. Citizen of Wi	USA	iu y r
the triffe	Ӓ									
with 15 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.					( Specify Yes or N			can Indian, Black,
eath iten	튁	1 X Never Married 2 Married Armed Forces?	If Y	res, specify (	luban, Me	exican, Pu	erto Rican, etc.)	Whit	e, etc.	
ter d		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black								ck
rs af ural min	by	or Dates:	Deceder				of work done	16b. Kind of Bu		
hou hou Exa	ompleted			nost of workin						
36 thin 72 than than edical	e e	7		studen	. 4-			scho	100	
Ned	Ē	<u> </u>		Studen						
Hyg the	ပ	17. Father's Name (First, Middle, Last)			18.1	Mother's N	lame (First, Middle		-)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Thomas Streams						Griffin		
Ould Me	۵						or Rural Route No			
MD id 2 sho lith and m 27 is aumat		Joel Griffin / Mother	1930	McCullo	h Str	reet; ]	Baltimore,	Maryland	21217	7
				sition (Name	of cemete	егу,	Date	20c. Location	- City or	Town, State
Ses 1 t of 1		1 XX Bullal 2 Cremation 3 Removal from State	•	ther place)			o. ha lagga	n a		
Baltimore, permit. Pages I a Department of He Important: If ite		4 Banadan C Guler Openiy.		Cemeter			04/23/2008	Baltimo		
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee		Name and Ad				eral Home,		
m 707.5	(Y) Y)	Lucia Vines					t; Baltimor			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	t enter t	the mode of o	lying, suc	ch as cardi	iac or respiratory a	rrest, shock, or he	art	Approximate Interval Between Onset and
Medical	ii ii	Immediate Cause (Final disease a. Gunshot Wound of Head								Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):								
		h `								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	듣	Courte Enter Underlying Cause (Disease or injury that initiated								
	Examiner	events resulting in death) Last Due to (or as a consequence of):								
trans	<u>=</u>	d								ļ
58760, Krificate be executed ling physician and as the burial - transit	n/Medical	UNPENDED AMENDED								
Box 68760, e death certificate be the attending physic of for use as the bur	ĕ	IF FEMALE: 23c. If yes, outcome of pregnancy						23d. Date of	f deliver	y
187 rtific rng p	<u>_</u>	23b. Was decedent pregnant in the past 12 months?	E F	etal death	3	Ectopic pr	egnancy	Month	Γ	Day Year
× 6 th cell	<u>:</u>	Pregnant at time of death	5 🗌 o	ther (Specif)	)					
d for	Physicia	1 Yes 2 V No 9 Unknown 9 Unknown								
lack the		Part II. Other significant conditions contributing to death but not resulting	g in the	underlying ca	ause give	n in Part I	. 23e. Did	tobacco use cont	ribute to	the cause of death?
ords, P.O. Box 6 w requires that the death cer is been signed by the attendit should be detached for use	by						1Y	'es 2 🗸 No 3	Pro	bably 4 Unknown
da,	ompleted						24a. Wa	s an 24b.	Were au	topsy findings available
Orc IW re as be	ble						aut			completion of cause of
He la	E O								1 Y	es 2 No
n: T rtiffic or, p	ပ	25. Was case referred to medical		26	Place of	Death (Ch	neck only one)			
of Vital Records, g Physician: The law require the this certificate has been si neral director, page 2 should be	Be	examiner? Hospital:   Innationt 2   EP/O	utpatien		O#	or:	lursing Home 5	Residence 6	Othe	r:
Phy ral d	မ	THE Z INO	Time of		c, Injury a			e how injury occur	rred	
n of ding Ph	ü	1 November 1 FOLIA	JND:			2 V No	Subject st			
Division In or Attendir Is after death. at Director: A	ati	2 Accident Investigation Apr 14, 2008 0930			-					
Vis or A Direction by	ijij	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, stre	eet, factory, o	ffice build	ding, etc.				ural Route Number, City
intal District	Certification:	4 Homicide determined (Specify) Rowhouse					1925 North	Patterson Park	Avenue	e, Baltimore, MD
Hosp 24 hc Fun Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occu	urred at the ti	me, date	and place	, and due to the ca	use(s) and manne	er as stat	ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	one) 2 Medical Examiner: On the basis of examination and/or in	nvestiga	ation, in my o	pinion, de	eath occur	red at the time, da	te and place, and	due to th	ne cause(s)
T w. To	Me	and manner stated.  29b. Signature and title of certifier		29c.1	icense n	umber		29d. Date sig	ned (Mc	inth, Day, Year)
		his his mo			D.C.M.			April 15, 2		
								7.,0.11 10, 2		
2		30. Name and address of person who completed cause of death (Item 23a)								
7		Ling Li, MD Assistant Medical Examiner 111 Penr	n Stre	et, Baltim	ore, MI	2 <b>12</b> 01 ر				
	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	100							
Regis	trar	APR 2 2 2008	X	-						
DHMH 17 Rev 1/2	001	ÖR	IGINA	AL			0	CME		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 6:05 PM Jayzena Haskins 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner ALTIMORE Mos BALTIMORE If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 7/1/1937 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Min. Months Hours 1 🗆 M 2 🗗 F 213-32-4590 Maryland Director 70 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 10a. State 10b. County 1 XYes 2 □ No Director Baltimore N/A Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA Funeral 2634 Oswego Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No à 3 → Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Company 12 Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Gallop William Gallop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2634 Oswego Avenue, Baltimore, Md. 21215 <u>Anthony Haskins</u> 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_ 5 ☐ Other (Specify) 4/18/2008 Baltimore, Md. Cemetery rbutus Signature of Funeral Service Licenses <sup>22</sup>Estep Brothers Funeral Home 1300 Eutaw Place, Baltimore, Md. 21217 art / Enter the ease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest she for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea e or condition resulting in death) **Physician** /Medical Due to (or as a consequence of), Examiner al Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi / E Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown کے signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No certificate 2 | No 1 □ Yes 1 TYes Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ٥ 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature Date filed (Month, Day, Year) State APR 2 2 2008 'Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oyd Hunter, Jr.		tment of Health and Mental Hy ificate of Death	ygiene	00 1224
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year April 17, 2008	3. Time of Death 0518 hrs
, I Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	
	568 Windsong Drive	Aberdeen	Harford	Birthplace (State or
Funeral Director	5. Social Security Number 6. Sex 77. Age (In yrs. Ias 18-74-7642) 1 7. Age (In yrs. Ias 49	st birthday) Yrs.  If Under 1 Year If Under 24Hrs Months Days Hours Min.	<b>→</b> ` 1∈.	creign Country)
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	Fown or Location Aberdeen		10d. Inside City Limits
Varyland 28a-f show any d at once. rector	MD Harford B	altimore		1 Yes 2 100
the Maryland a or 28a-f sh tified at one Director	10e. Street and Number  See WindSown Drive	10f. Zip Code	10g. Citizen of What (	Country?
with then s 23a penotii	11. Marital Status 12. Was Decedent Ever in U.S			merican Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once leted by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		S IONY
urs afte tural", miner	Wildowed 4 Divorced in test Give real	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of v		ess/Industry
6 172 hou an "nai cal Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		
215-0036 be filed within 72 hour ntal Hygiene. Red other than "natu ent, the Medical Exan Be Completed	17. Father's Name (First, Middle, Last)	Operator  18.Mother's Name	e (First, Middle, Maiden Surname)	house.
21215-003 uld be filed withi merked other tt event, the Med	Floyd Hunter, Sr.	Mar		e
	19a. Informant's Natice Relationship (Type, Print)	19b. Mailing Address (Street and Number or Supplemental S	(2)	State, Zip Code)
Baltimore, MD permit, Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati		lace of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - Cit	ty or Town, State
Baltimore, vermit. Pages I ar Department of He important: If ite injury or other tr	Bullar 2 Cremation 3 Removal non State	22. Name and Address of Facility Co	123/2008 Baltima	ore, MD
Baltimo permit. Pag Department Important: injury or of	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	osrin C. Greene F	uneral services
Physician	23a. Part I. Enter he disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Vedical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease a. Intraoral Gunshot Woun			Death
	or condition resulting in death)  Due to (or as a consequence of)  b.	):		
iner	Sequentially list conditions, if any, leading to immediate cause. Friter Underlying Course	):		
ed Insit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of	):		
a - tra	d.  UNPENDED X AMENDED	TIL G070 1 100 100		
760, icate be exphysician the burial	IF FEMALE: 23c. If yes, outcome of pregnant in the 23b. Was decedent pregnant in the		23d. Date of de	i
OX 6876C eath certificate eath certificate eath certificate for use as the b	past 12 months?  1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregn  ath 5 Other (Specify)	ancy Month	Day Year
	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
P.C es that igned be deta	`	Soluting in the distance of the second great in the second great gre	1 Yes 2 No 3	
ords, w requir s been s should b			autopsy pric	re autopsy findings available or to completion of cause of
tal Records, isan: The law require certificate has been si, ector, page 2 should b. Be Completed				eth? Yes 2 No
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should TO Be Completee	examiner?   Hospital:	26.Place of Death (Check ER/Outpatient 3 DOA Other Nursi	conly one) ing Home 5 Residence 6	Other: Scene
of Vital ling Physician: After this certifuneral director,	27 Manner of Death 28a, Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject shot self	
sion ttendit death. ctor: A y the fu	1 Natural 5 Pending Apr 17, 2008	0510 hrs 1 Yes 2 V No		O I D I N I D O
Division o Hospital or Attending 24 hours after death. Finneral Director: After tely filled in by the fune	3 Suicide 6 Could not be determined (Specify) Single Fam	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) 568 Windsong Drive, Aberdee	
To the Hospital within 24 hours a To the Finneral completely filled	29a Certifier	ge, death occurred at the time, date and place, an	d due to the cause(s) and manner as at the time, date and place, and due	s stated. to the cause(s)
T with To To To To To To To To To To To To To	29b. Signature and time of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	Mohn Braself, MD	O.C.M.E.	April 17, 200	8
10	30. Name and address of person who completed cause of death (Item Melissa Brassell, MD Assistant Medical Examin		21201	
State		ire		
Registra  DHMH 17 Rev 1/2001	APR & & LOUD COSSION.	ORIGINAL		
OCME 2006	OCME	ONIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 RONALD Κ. HUBBELL SR. April 1:21 p M 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7851 Harold Road Dunda1k Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 MM 2 □ F 215-70-7334 47 Director May 09, 1960 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Important: If tier 27 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira I walk at Examinar man be rediled at any injury or other traumatic event, Ira I walk at Examinar man be rediled at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director Maryland Baltimore Dunda1k 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 7851 Harold Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor 12 Skilled Tradesman 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) J. Ha11 George A. Hubbell Jr. Bertha ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 55 Ambo Circle, Middle River, Maryland 21220 Ronald K. Hubbell Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 04-24-08 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility.
McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. P / (1. Enter the disease, or complications that caused the death, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Metasta **Physician** pato cellul Carcenama 3month 5 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 687605 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown Month Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 10 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 45

3

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 2 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia road, Baltimore ND 5. SIVASATUAM, Swife 208, Philadelphia road, Baltimore ND

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 21, 2008<sup>ear</sup> Teresa Leigh Hannibal 5:50 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Timonium Baltimore Stella Maris 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 3/30/1963 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Months Days Hours Min. Maryland 213-92-0712 45 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show MD Baltimore Baltimore Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7823 Oakleigh Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XINo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXXVo <u>\$</u> Specify: Specify: White 3 ☐ Widowed 4XXDivorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Perring Athletic Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Geraldine Henderlite Herbert Hoover Bise 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Bise / Sister-in-law 707 Rosefield Court Belair, MD 21014 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. Hilltop Serv. Corp. 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4/23/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Towson, Maryland 21204 1050 York Road Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transi Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 □Yes 1 ☐ Yes 2 ☐ No 2 💢 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies within 24 hours after death.

In the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a title of certific dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 10 ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State APR 2 2 2008 Registrar

DHMH 17 Rev 1/2001

21

TERESA HANNIBAI

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year HOWARD 7:15 PM APRIL UCILLE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–10–1915 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 92 217-32-8897 Director VA Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 6406 Jefferson Place 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗙 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the M. dical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Moore 2 Lucy Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Henry Howard / son 6406 Jefferson Place; Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Lake View Mem. Park 04-19-2008 4 □ Donation 5 □ Other (Specify) Sykesville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** 2 DAYS /Medical Due to (or as a consequence of): Examiner ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Hospital or Attending Physician: The law requires that the death certificate be exect Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) the 9□Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed DYSLIPIDEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autoosy certificate performed' 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D KESODOI 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET BALTIMORE 3001 S. HANOVER HARBOR HOSPITAL 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 2 2008 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Marylar  1 - State Registrar		ırtment of F <i>rtificate of l</i>			- /	1000	12053						
			Decedent's Name (First, Middle, Last)				2. Date of Dea	of Death 3, Time of Death								
	Physici /Medi		Paul Anthony Hupfer		Month Day Year April 21 2008 7:00 A											
200	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De		4c.	County of Death	7.700 12						
5			Gilchrist Center		Towson	ı			Baltimor	e						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi		h v. Year)	9. Birth	place (State or Foreign						
	Director		215-44-0494 X M 2□ F 62	Yrs.		Tiouio IIII			945 MD							
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ity, Town or Loc	cation				1	0d. Inside City Limits						
	Maryl f sho	ō							1	1 ☐ Yes 21 No						
	the t	Director	MD Baltimore  10e. Street and Number	Sparks	10f. Zip Code		1	10a Citi	izen of What Cour							
	3a or		831 Walters Lane			1152		rog. Oil	USA	iu y :						
	death ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U	J.S. 13. V			(Specify Yes or No- erto Rican, etc.)		14. Race - Americ	can Indian,						
ပ္	after or ite		1 Never Married 2 Married 1 1 Yes 2 1 No		_		erto Rican, etc.)		Black, White,	etc.						
8	ours iral",	d by	3 Widowed 4 Divorced Year or Dates:		∐Yes 2√ No	Specify:			Specify: white							
<u>7</u>	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupa	vorkina	16b. Ki	nd of Business/In	dustry							
12	vithin sne. than	mp	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	O NOT use retired	0		<b>.</b> 1								
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Pesical Examination of other a		17. Father's Name (First, Middle, Last)	Projec	t Manage		ame (First, Middle,		ustrial :	Defence						
ä	d be i	Be C	Francis John Hupfer, Sr.				stine L.		,							
₹	should Mark	ပ္	19a. Informant's Name/Relationship (Type. Print)	19h Mailin	Address (Street :		Rural Route Numbe			Cadal						
2	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Prodest Examination in the Invited 2t		Mary Hupfer/wife				arks, MD			Code						
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.			Place of Dispos			Date		cation - City or To	wn, State						
Ë	Page nent c nt: If		Kill Bullar 2 Li Cremation 3 Li Removal from State		alley Me	/	24/08 Gardens	Time	onium, M	D						
aĦ	mit. partm porta porta / Inju		21. Signature of Funeral Service Aper see		Name and Addres	s of Facility			-							
n	P P P P P		Bryan W. Clary	1	Lemmon F	uneral	Home of D	ulaı	ney Vall	ey, Inc.						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate													
	Physician		Immediate Occur (Final)	1-1-1	. A DA	190	METHS	11.7	70	Interval Between Onset and Death						
	/Medical		resulting in death)  a.   Due to (or as a conseq	CHIV	un,	11/6/19/5/	17.1	16	IIIUNIA S							
	Examiner		Sequentially list conditions	b. — Due to (or as a consequence or).												
7	pe tie	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
	ecute and -trans	Kam	c.													
Ď,	be ey ician burial		Due to (or as a conseq	uence or):												
08/PO	tificate be executed g physician and as the burial-transit	edical	d													
_	+ 2,0	/Me	IF FEMALE: 23c. If yes, outcome of pregnant	,												
Ř	leath atter	hysician/M	in the past 12 months?	aldeath 3 🗌	Ectopic pregnancy Other (specify)	,		1	23d. Date of delive Month	f delivery Day Year						
j.	the c y the iched	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 6 9 ☐ Unknown 9 ☐ Unknown	O Unknown												
	requires that the death cer sen signed by the attendin nould be detached for use	by P	Part II. Other significant conditions contributing to death but not rest	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
cords,	quire; an sig uld be			_ 1 □ Y	es 2[	2 □ No 3 □ Probably 4 🛕 Unknown										
ဝ္ပ	s bee	Jete		24a. Was												
ř	To be perfectly and the perfec								prior to con death?							
Ī	lan: '	Be	25. Was case referred to medical			26. Place of De	1 ☐ Yes eath (Check only on	2 No	1 □ Yes	2 ∐No						
>	nysic nis ce direc		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ DOA Othe		Home 5 Resid		☑Other (Specif	n HOSPICE						
0	fter the neral	Ë	27. Manner of Death 28a. Date of Injury  1 Natural 5 Dending (Month, Day, Year)	28b. Time of Injury	28c. Injury Work			28d. Describe how injury occurred								
VISTOR	endir sath. or: Al	atic	Accident investigation	- 3.												
≝	r Atter de lirecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specif	me, farm, stre	et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
2	urs af		4				1									
	Hosp 24 hou Fune tely fi	edical	29a. Certifier (Check only (Ch	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place oinion, death occ	ce, and due to the c	ause(s)	and manner as s	tated.						
	To the Hospital or Attending Physiclan: The law within 24 hours after death.  To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 st	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License											
	<b>₹</b> ₹ \$ 8	_	ESS. Signature and time or certifier						od. Date signed (Month, Day, Year)							
	1	-	20 Name and address	- 00-1 (T		4395	/	4 1718	14 21.	2008						
	10		30. Name and address of person who completed cause of death (Item DANIFILE NOBSEMAN, MD 65765			- S11.T	2-209 A	ALTI	MUDS M	0 2,204						
	Stat	e_	DANIEUE DOBERMAN, MD 6505 31. Date filed (Month, Day, Year)  ADD 2, 2, 2008  32 Registrar's Signa	the And	10000	, Sull			1.00 000 1000	2,207						
	Registra		ADD 997008 EREGISES	5 55												

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Himore If Under 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F 3-16-Director une 27, 1920 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral Dad r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic event, theone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Debastian DUISA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and z Pa Koad Emerald Jenevieve Herbst 2821 rkuille MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 16 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-24-08 memorial Gardens Maryland 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville
8800 Harford Road Parkville mD 21234 21. Signature of Funeral Service Licenses Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Dua to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician. The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a, Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 0 12871 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 🥡. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Leroy W. Joyner 4-18-2008 4:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Balto.Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 → M 2 □ F 213-28-0661 77 7-3-1930 Director Md. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evant in Frust to exerting any Injury or other traumatic event, I've Medical Evant in Frust to exerting any once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Farwell Ct. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☐ If Was, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) yrs Electrician Balto. Co. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Joyner Wife <u> 15 Farwell Ct.</u> Nottingham ,Md 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bayview Crematory 4-22,2008 Balto.Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final mo **Physician** bresi disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 Yes 2 Who certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) (CO) Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature N. Charces St Dowsen MD ZILOY 2 30. Name and address of person who completed 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 5, 6:45 PM M 2008 Joe Walker Jenkins /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 3655 1st Avenue Edgewater If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 21 1940 Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 18 M 2□ F 68 Virginia Director 230-48-9241 Usual Residence of Deceden 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Edgewater MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 USA 3655 1st Avenue "naturel", or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status be filed within 72 hours after on the Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 57-63 Specify: White δ 3 ☐ Widowed 4 X Divorced the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professional Ballroom Dancer permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If Item 27 is marked other the Dance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenkins Elizabeth Jenkins Fannie Joseph Hannas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Smith - Sister 639 Killarney Drive, Sebring, FL 33875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/17/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscleratic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificete hes autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 XYes 2 □ No funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide efter within 24 hours e To the Funeral D t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) and address of person who complete 18X lowes my 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar 22

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2 Date of Death 3. Time of Death Day **Physician** .00AM 4 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country Louisanna Date of Birth Social Security Number 6. Sex vrs. last birthday) 7. Age **Funeral** Months Days Hours Min 1 M 2 F Yrs Director and lawo sidence of Decedent death with the Maryland 10c. City, Town or Location ene. than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at 1 Tes 2 □ No Funeral Director timore 10e. Street and Number 10g. Citizen of What Country? mit Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after Hygiene. 2 Married 1 Never Married 21215-0036 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 1:00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) econdary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any Injury or other traumatic event, Ital once. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma Be 2008 ပ abl 19a Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APRIL 18, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hon Service Licens 21. Signature ar Back 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Month Year Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 X No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🛣 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. the 29b. Signature and title of certifier 2 29c. License number 29d, Date signed (Month, Day, Year) 8 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Pajistrar's Signature State APR 2 2 2008 Registrar

DHMH 17 Rev 1/200

JASMINE

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21 1:05 a<sup>M</sup> 4 2008 Roberta C. Jansen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince Georges Laurel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Director 219-32-3789 70 June 12, 1937 MDUsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Prince Georges Laure1 Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15649 Mews Ct. 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2KNo Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Williams Roy Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Jansen/Husband 15649 Mews Ct., Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Ž5, April 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Crownsville, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral and Cremation 1 reduce M01411 1 2nd Ave. SW, Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD Exacerbatory /Medical Due to (or as a consequence of) Examiner Hyperkalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Anemia burial-tran Due to (or as a consequence of): physician Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 → Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 1∐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ☑ Natural 2 ☐ Accident 5 Pending Injury the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only To th.
within 2.
To the Fig. one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0064760 4/21/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, 7300 Van Dusen Rd., Laurel, MD 20707 Mythily Vancha, MD, 31. Date filed (Month, Day, Year)
APR 22 State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Joyce Kuhla 3:10 M APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MINGRSITY OF MARYLAND BALTIMOBIE 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 05–10–1934 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 182-28-9868 73 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📆 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Flintlock Drive 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Asst. Bank Stationary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Knappenberger Beatrice Berger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Kuhla (Husband) Flintlock Drive Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens 04-12-2008 | Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Sig a ure of Funeral Service Licensee Stefanio Inc. 610 W. MacPhail Rd Bel air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** INTRACEPEBRAL W-124R HEMORRHAGE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐Live birth 3 □Ectopic pregnancy Month Day Year signed by the aid of be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2XNo 3 Probably 4 Unknown cate has been si , page 2 should I 1 🔲 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1□ Yes 2 No certificate Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 3□ DOA this ( ို 2 ER/Outpatient 28c. Injury at Work? Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 Pending investigation within 24 hours after death.

To the Funeral Director: At completely filled in by the form 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

10

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of p

31. Date filed (Month, Day,

Year)

Greene

n who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year John Francis Kelly April 2008 17, 3:05 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-12-1923 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **X**□M 2□F Months Days Hours Min. 218-18-4503 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits Y☐Yes 2☐No Balto. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4340 Berger Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (∆Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Circuit Court of Balto.Ci 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Kelly Catherine M. Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Eierman 7837 Westmoreland Avenue Balto.Md.21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 4-21-1008 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. coee Hall. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Sep. Si. C. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year time of death 5 ☐ Other (specify) t not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at

should be filed within 72 hours after ond Mental Hygiene.

marked other than "natural", or itel

Pages 1 and 2 s ment of Health an

ö

Injury

more,

/Medical

Director

Funeral

Completed by

Be

ပ

Md.

The law requires that the death certificate be executed

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

attending physician and for use as the burial-tran signed by the ail to be detached for certificate spital or Attending Physician: The nours after death.
Ineral Director: After this certificate y filled in by the funeral director, par

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t
art II. Other significant condition	ns contributing to death but

Lardiocenic

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29b. Signature and title of certifier

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D20907 completed cause of death (Item 23a) (Type, Print)

North Charles

Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Marie 31. Date filed (Month, Day, Year)

2 2 2008

na m

08-02796 Sharif M. King Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

narif M. King	1.	State of Maryland / Department of Healtr For State Certificate of Death		Reg. No	200	18 1296
Physician/	Re	gistrar Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
/Physician ledical Examine		SHARIF M. KING		April 9, 2008		1820 hrs
of the		a. Facility Name (if not institution, give street and number)  4b. City, To	wn, or Location of Death		4c. County of Death Prince George	·c
	ı	2002 Vicalage Court	Marlboro			hplace (State or Foreign
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months			Cou	untry)
Director	1	524-15-3980 1X M 2 F 39 Yrs.		02/13/1	969 GER	MANY
- M &	-	sual Residence of Decedent  Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
w any		ou. State				1 X Yes 2 No
Maryland 28a-f show d at once.	<u> </u>	MD PRINCE GEORGES MITCHELLVILLE  Oe. Street and Number 10f. Zip (	Code	10g. C	Citizen of What Cour	ntry?
he Maryland to 28a-f sh	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	2602 VICARAGE COURT 2072	71	US	Δ	
1/ - 2		1 Marital Status 12 Was Decedent Ever in U.S. 13, Was Deceder	nt of Hispanic Origin? ( S	Specify Yes or No-	14. Race - Ameri	can Indian, Black,
r death with or items 23 must be no	<u> </u>	1 Never Married 2 X Married Armed Forces? If Yes, specify	Cuban, Mexican, Puert	o Rican, etc.)	White, etc.	CIZ
fler de	- 1	Widowed 4 Divorced of Yes, Giva Year ATREORCE 1 Yes 2	X No specify:		Specify: BLA	
atura atura	<u>o</u>  -	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	Occupation (Give kind of king life. DO NOT use re	f work done 169 etired)	b. Kind of Business/	Industry
5 72 ho rn "n cal Ex		Elementary/Secondary (0-12) College (1-4 or 5+)  SYSTEMS ENG	TNEED		GOVERNMEN	T.
within within iene.	Сотріете	7. Father's Name (First, Middle, Last)	_	ne (First, Middle, Maid		<u> </u>
1215-0036 de filed within 72 hours after fental Hygiene, varked other than "matural", event, the Medical Examine.			VERA SUI			
	o Re	WARREN KING, JR.  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address	(Street and Number o	r Rural Route Number	r, City or Town, State	e, Zip Code)
and 2 shou lealth and I tem 27 is retraumatic	-		AGE COURT 1			
e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disposition (Nam crematory or other place)			Oc. Location - City of	
nor ages ant of at: If		1 XBurial 2 Cremation 3 Removal from State MARYLAND VETER 4 Donation 5 Other Specify:	11174	/18/2008	CHELTENHA	M, MD
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	1	21. Signature of Funeral Service Licensee 22. Name and	Address of Facility J			
ii ji ga 🎘	1		NDOVER ROAL			5 Approximate Interval
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	of dying, such as cardiad	correspiratory arrest,	SHOCK, OF HEAR	Between Onset and Death
, ∞ /Medical kaminer	ı	Immediate Cause (Final disease a. Acute Bacterial Pneumonia			<del></del>	16 31
	1	or condition resulting in death)  Due to (or as a consequence of):				
	틸	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that Initiated  C.  Due to (or as a consequence of):				
Transit and State	E	events resulting in death) Last  d.				
Box 68760, re death certificate be executed the attending physician and ned for use as the burial - transit	Medical	X UNPENDED AMENDED 23a,27 per ME g878 4/23	3/08 amh			
60, ate be shysical	Med	IF FFMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	
687 ertific ding p	an/l	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe		gnancy	Month	Day Year
OX eath c	Physician/N	4 Pregnant at time of death 5 Other (Special Yes 2 No 9 Unknown g Unknown	еспу)			
	۔	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			to the cause of death?
Records, P.O. The law requires that th icate has been signed by page 2 should be detach	ð			-		obably 4 🗹 Unknown
ds, requir	Completed			24a. Was an autopsy	prior to	autopsy findings available completion of cause of
e law e has l	d III			perform 1 ✓ Yes 2	ed? death	
Refiser	ပိ	25. Was case referred to medical	26.Place of Death (Che	eck only one)		
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	o Be		DOA Other Nu		esidence 6 🗸 Ott	ner: Scene
of \officers	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?		w injury occurred	
ion tendir eath. or: A	atio	Natural 5 Pending	1 Yes 2 No		t and Minister on	Rural Route Number, City
ViS or At Orred Direct in by	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.	or Town, Sta	ete)	Rulai Route Number, Oity
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi	Certification:	4 Homicide determined (Specify)	C data and alana	and due to the cause	(e) and manner as s	tated
ne 110 n 24 h	cal	29a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in n	ne time, date and place, ny opinion, death occurr	ed at the time, date a	nd place, and due to	the cause(s)
Somptification (C)	Medical	and mariner stated.	9c. License number	1	29d. Date signed (i	
	2	and D	O.C.M.E.		April 10, 2008	
		30. Name and address of person who completed cause of death (Item 23a)				
0		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21	201		
St.	ate	31. Date filed/Month, Day Year 000				
Regist		APR 2 2 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** David M. Lyles 08 9:44P M 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1703 Pebble Beach Drive Mitchellville Prince George 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral X**□M 2□F 578-52-6432 Director 66 Wash.DC 5-11-41 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "naturel", or Items 23a or 28a-f show event, the Medical Examiner must be notified at MD Prince George Mitchellville 1 ☐ Yes ¾☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Pebble Beach Drive 20721 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 → Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is merked other than eny injury or other traumetic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) Wash DC Gov't Personnel Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Lyles Lillie Sneed 19a. İnformant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Pebble Beach Dr., Mitchellville, Md20721 Joan P. Lyles/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/21/08 Brentwood, MD Ft. Lincoln Cem 4 ☐ Donation 5 ☐ Other (Spegify) 22. Name and Address of Facility
Hari P. Close F.Svs, PA 21. Signature of Funeral Service Licensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONCOR **Physician** small cell NUN resulting in death) /Medical Due to (or as a consequence of) 6 Month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA hospica this 27. Manner of Death 28a. Date of Injury (Month, Day Year) ion: 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Certificat 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After the propered filled in by the funeral within 24 hours a To the Funeral I

> State Registrar

29b. Signature and title of certifier

SHARMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1400 forest glen Rd #435

D 9041119

SRVER Spring Md 20910

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Triccar 30. Name and address of person who completed

MD RESOOD

2008 APRIL 16

10 ADEKUNLE OBISESAN

cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL

3001 SOUTH HANOVER STREET, BALTIMORE-MARYLAND

State Registrar 31. Date filed (Month, Day, Year) APR 2 2 2008

32. Registrar's Signature A BELLEN

Svetlana Anatorye	1	riva Latash For State	Sta	ate of	f Marylar	id / D		ment of iicate of			Menta	al Hyg		Reg. No.	20	0 8	1296	
Physician	1	1. Decedent's Name (First, Middle,Last) 2.									Date of Dea	of Death						
Medical Examine		Svetlan.											April 18,	2008			1400 hrs	
4	í	a. Facility Name (if no 7511 Spring La				ber)		14	b. City, T Bethe		ocation of	Death		4c. County of Death  Montgomery				
Funeral		. Social Security Num		6. Sex		. Age (Ir	ge (In yrs. last birthday)			r 1 Year	If Under	24Hrs.	8. Date of B				Birthplace (State or	
Director		343-82-3			2 X F		46	Yrs.	Months	Days	Hours	Min.		•	Fo	oreign	<sup>try)</sup> Russia	
	h	Jsual Residence of De		1 NI	2 <u>1</u>		+0	115.					Nov.	20,	1901		" Kussia	
any	Ī	0a. State 10t	b. County		<del></del>	100	c. City, To	wn or Locati	on								0d. Inside City Limits	
Maryland 28a-f show d at once,	٦	Maryland	Mont	gom	ery		Bet	hesda									Yes 2 No	
the Maryland a or 28a-f sh lifted at onco		10e. Street and Number							10f. Zip					10g. Cit	izen of What	Countr	<b>y</b> ?	
th the		7511 Sprin	ig Lal							0817					ted Sta			
r death with	nere	Marital Status     Never Married	2 M	arried 1	12. Was Dece Armed For	ces?							cify Yes or N lican, etc.)	lo-	14. Race - A White, e		n Indian, Black,	
ter de		3 Widowed	4 X Div	orced If	1 Yes Yes, Give Year	2 X	No	1	Yes 2	v No	specify:				Specify: W	hit	۵	
vurs afte		15. Decedent's Educa		10	r Dates:	comple	ted) 1	6a. Deceden	t's Usual	Occupatio	n (Give k			16b.	Kind of Busin			
72 hc 72 hc	Completed	Elementary/Second	ary (0-12)	$\top$	College (1-4	or 5+)		_		_	DO NOT L	use retire	·d)					
5-0036 lied within 7 Hygiene. I other than	ᇍ				2			Cosm	etol						smeto1	.ogy		
filed and the filed of the file		17. Father's Name (Fir								18			First, Middle					
2121 2121 build be fi Mental I marked ic event,		Anatoliy '			e, Print )		···	19b. Mailing	Address	(Street			Malys			State, Z	(ip Code)	
MD d 2 shot tth and n 27 is numatic	-	19a. Informant's Name/Relationship (Type, Print)  Elizaveta Latash/Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State College,																
e, land I and Healt Healt item		20a. Method of Dispos	ition					ce of Dispos matory or oth	ition (Nan	ne of cem	eterv.		Date 1 21,		Location - Ci			
altimore, mit. Pages I at partment of He portant: If ite ury or other tr	١	1 X Burial 2 14 Donation 5			Removal from	n State		c Cree				20		Wa	shingt	on.	D.C.	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Department of Health and Mental Hygiens Trains are seen than "matural", or items 23a or 28a-f should ray or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funer	ral Service	License	е	MO 1	1360	22. N Betl	lame and	Address of Chevy	of Facility Chas			mphr 7 Wis	ey Fune	ral Aven	Home, ue, Bethesda	
Physician	+	3a. Part I. Enter the d						Marr o not enter ti	vland ne mode o	$\frac{20814}{209}$	t uch as ca	rdiac or	respiratory a	rrest, sh	ock, or heart		Approximate interval	
/Medical		failure. List only of Immediate Cause (Fin		0	i line. i <b>rrh</b> osis d'	f live	r										Between Onset and Death	
n xaminer		or condition resulting in death)  Due to (or as a consequence of):																
,	Sequentially list conditions, b												-					
	if any, leading to immediate Due to (or as a consequence of):  Cause. Enter funding Cause  Consequence of living in the latitated Consequence of the latitated Consequence of the latitated Consequence of living in																	
recuted transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):																	
be es	dica	UNPENDED			AMENDED		·											
Box 68760 he death certificate by the attending physined for use as the but	Ĕ [2	F FEMALE: 3b. Was decedent pre	egnant in t	ne	23c. If yes, or		of pregna	· — -	tal death	3	Ectonic	pregnan	·CV	23	3d. Date of de Month	elivery Da	y Year	
× 66 h cert tendin use a	sician/M	past 12 months?					e of death	, <del>-</del> =	her (Spe	_	Lotopio	program	,		Monar	-	, rou	
Box e death c the atten ed for us	Phys	1 Yes 2 No	g 🗹 Un	known	9 Unknow	vn												
p, P.O. irres that the signed by 1 dbe detached.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									le. Did tobacco use contribute to the cause of death?  Yes 2 ✓ No 3 Probably 4 Unknown							
S, F quires en sigr	eted						-						24a. Wa				psy findings available	
Cords,													aut	opsy formed?	pric		mpletion of cause of	
Rec The l	om Comp												1 ✓ Yes			Yes	2 No	
Division of Vital Records, is or Attending Physician: The law requirents attendent. In Director: After this certificate has been sited in by the funeral director, page 2 should be attended.	Re	25. Was case referred examiner?	to medica		spital: 1 In					10	of Death ( Other <sub>4</sub>			75.				
Physic er this real dire		1 ✓ Yes 2 27. Manner of Death	No		28a. Date c	patient f Injury	L/	R/Outpatient 8b. Time of I			y at Work		Home 5		dence 6 🗹		Scene	
nding Ph th. :: After t	<u> </u>	1 00 11-1	5 Pen	ding	(Month,	Day, Year	)		.,,.,,		es 2		ZOG. DOCOND	0 11047 11	ijary coodinod			
ivision or Attence after death Director:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and								and Number	lumber or Rural Route Number, City								
Div pital or ours aft reral Di filled ir		Suicide 6 Could not be determined (Specify)  Specify)																
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the build the first of the first	<u> </u>	( Orrown only		-	n: To the best on the basis of	-												
To with To com	影	and manner stated.  29b_Signature and title of certifier  29c. License number							29d. Date signed (Month, Day, Year)									
		Montonie Me Kull O.C.M.E.							April 19, 2008									
	$\vdash$	30. Name and address		who co	mpleted cause	of deal	th (Item 2	3a)										
10		Margarita Kor	ell MD.	Ass	istant Med	ical Ex		111 P	enn Sti	eet, Ba	altimore	, MD 2	1201					
Star Registra	-		PR 2			Mess.	Jigriature	Con	ule							1		
DHMH 17 Rev 1/200	_					-		ORIGINA	L							00	OME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** .15 PM Joseph 2008 ona 15 NEVIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore YA Baltimore Medical Center if Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F Pennsylvania 71 Oct 6, 215-32-8281 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Anne Arundel Jessup Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20794 USA 1633 Colesbury Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1961 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White δ 3 ☐ Widowed 4 🕅 Divorced Year or Dates: Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than " any Injury or other traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Artist Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Will Nevin Carter Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 446 Thumper Drive Ranson, West Virginia 25438 Andrew T. Long, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/23/08 Baltimore, Maryland 21. Signature of Funeral Service (censee MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or an a consequence of): **Physician** resulting in death) /Medical **Examiner** Candidiasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Sophagea Due to (or as a consequênce of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 1 ☐ Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached f 1□Yes 2□No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by Fbrilla 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2K No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို 1 🗌 Yes 2 No 1 Inpatient 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 冠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician; ithin 24 hours after death.

o the Funeral Director: A

ompletely filled in by the fu the within 7

1/1 State

31. Date filed (Month, Day, Year)
APR 2 2 2008

Angela Frates

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ancela Frates, Univ. MD 225. C 3 Registrar's Signature

225. Greene

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

21

Baltmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 14:50 FM 14 Eugene 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore University raryland Medical Lost n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F North Carolina Director Feb 241-58-8919 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 225 Otis Drive 21144 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑X☐ Yes 2☐ No
If Yes, Give
Year or Dates: 1958-78 Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) 10 Police Officer Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Willis ဂ George Lynch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Otis Drive Severn, Maryland 21144 Sun Lynch/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4/23/2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Funeral Service Lice 21. Signatura 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Odenton, Maryland 21113 1411 Annapolis Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Brain herriation Physician days /Medical Due to (or as a consequence of): Examiner ede cerebral Sequentially list conditions, transport of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed CHARLESTON APPROVED BY MEDICAL accidenta the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a 1 Ves 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

y⊆Yes 2□ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of the funeral 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 12/20080612 AM after death. 1 Tes 04 accidental ace of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 5-: 12: office 2597 Dorsey Rd Glen Burnie, MD 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066185

State Registrar

DHMH 17 Rev 1/2001

6 reenc

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simmors

APR 2 2 2008

31. Date filed (Month, Day, Year)

5.

Registrar's Signature

11

29c. License number

D31025

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carla wolf Rosen Inal M.D., 608 Edgewale Road, ballin more M.D.

32. Registrar's Signature

25151

29d. Date signed (Month, Day, Year)

2008

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

luntries of pur sand

2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar Amend 19a, perFH 0879 5/21/08 TT Certificate of Death Reg. No.\_ 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 7:30A Hiam 4-19-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Balto. Co. Balto. Oakcrest Residence If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 M 2 □ F 84 Yrs. Director 8-23-1923 Md 216-16-6704 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Lygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Balto. Co. Parkville Μd 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21234 8810 Walther Blvd. Apt.3616 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary C. Finn ٩ Thomas P. Molloy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa L. Molloy 8810 Walther Blvd. Apt.3616 Parkville,Md.21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-22-2008 Gardens of Faith Balto.Md. 22. Name and Address of Facility 21. Signature of Funeral Service Schimunek Funeral Home 9705 Belair Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** stage atheroschootic cord guoscular disease /Medical Due to (or as a conseq in nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician and s the burial-trans Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1☐Yes 2☐No 9☐Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. draboles devento 1 Yes 2 No 3 Probably 4 Unknown been si shoufd Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy performed 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation efter death.

I Director: Ald n by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours aft To the Funeral Di completely filled in

15

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 22

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) a8800 Registrar's Sign

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Cei	tificate of	Death		Reg. No.	18	12969	
Phys	sician	1. Decedent's Name (First, Middle, La					2. Date of De		Year	3. Time of Death	
	edical	JAMES	V. MELTON				April	· · · · · · ·	2008	11:23 A.M	
Exa	miner	4a. Fecility Neme (If not institution, give				4b. City, Town, or					
		1501 Light Str			If I Indos 1 Voor	Balti		N,			
Funer Direct			Sex 7. Age (In y 12⊠ M 2□ F 74	rs. last birthday) Yrs.	If Under 1 Year Months Days			y, Year)	Count	lace (State or Foreign try) h Carolina	
yland	Ē	10a. State 10b. County	10c.	City, Town or Lo	cation				1(	0d. Inside City Limits	
Mar e-f sl	ģ	Maryland N/A		Baltime	ore					1   Yes 2 □ No	
th the	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of		try?	
23e	la I	1501 Light Str	eet			21230		U	.S.A.		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cub ☐ Yes 2 1 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	pecify Yes or No- b Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0020 d within 72 hours af giene. or than "netural", or the Madical Exam	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	! (Give I	ent's Usual Occu kind of work done O NOT use retire	durina most of wor	rking	16b. Kind of B	1		
21 will will will will will will will wil	j	5	O	Rest	aurant	Owner		Kes	taura	nt	
De fije	Be (	17. Father's Name (First, Middle, Last,				l _	ne (First, Middle,		16)		
aryla should I and Men	은	John V. Me	lton			Empress	s Mou	nce			
re, Maryland 1 and 2 should be file Health and Mental Hy em 27 is marked othe		19a. Informant's Name/Relationship ( Judy J. Melton	Type, Print) (Wife)			t <i>and N</i> um <i>ber or R</i> u Street, Ba				,	
altimore, mit. Pages 1 an pertment of Heal portant: If item 2		20a. Method of Disposition		. Place of Dispos	ition (Name of atory or other pla	ice)	Date	20c. Location -	City or Tov	wn, State	
Pages Pages nent of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y) (	Cedar Hi			04-24-08	Baltim	ore,Ma	aryland	
Baltim permit. Pag Depertment Important: I any injury o	- Suce	21. Signature of Funeral Service Licer	nsey)	/ 22. M 1	Name and Addre CCully-P	ess of Facility Olyniak I	uneral	Home P.	A. Marv	land 21230	
		23a. Peri1. Enter the disease, or commonds, or heart failure. List only	plications that caused the de one cause on each line.							Approximate Interval Between	
Physicia /Medica	al	Immediate Cause (Final	e. metas	latic	880	phone	al a	ancer	/	Onset and Death	
Examine	er	disease or condition resulting in death)	e. Due to	(or as a consequ	ience of):				-	0 1001111	
ש. ס	ne.			(	,						
X 68 / 600, entificate be executed ding physician end se es the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as e consequ	ence of):						
	Medical	that initiated events resulting in death) Last	Due to	(or as a consequ	ence of):						
COIDS, P.O. BOX of wrequires that the death certific been signed by the attending p should be deteched for use es!			d						1		
	Physiclan	Part II. Other significent conditions of	ontributing to death but not re	esulting in the un	derlying cause giv	ven in Part I.	23b. Did to	obecco use co	ntribute to	the ceuse of death?	
that the detection							101	'es 2□No	3 Probe	ably 4 (Unknown	
The law requires that the ste has been signed by the page 2 should be deteche	d by						Ode Mee		24b Wo	re autopsy findings	
requestion of the contract of	Completed						24a. Was e	med?	avai	ilable prior to	
D m SC	E G							~		eath?	
n: Th		05 )					1 🗆 Y		10	Yes 2 No	
Sicien certif rectc	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospitel:		3□ DOA Oth	26. Plece of Dea					
This and a contract of the con	7.	1 ☐ Yes 2 【 No 27. Magner of Death	1 Linpatient 2	☐ ER/Outpatient 28b. Time of	3LI DOA	4 LI Nursing H	ome 5 Resid			1	
nding ath. :: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c, Injui Wor M 1 🗆	rk? Yes 2 □ No	Edd. Doddingo ii	ow injury coodin	04		
or Atterded	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
To the Hospital or Attending Physicien: The is within 24 hours effer death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 12 Certifying Phyone) 2 Medical Exam	/sicien: To the best of my kr liner: On the basis of examir and manner stated.	nowledge, death nation and/or Inve	occurred et the tirestigation, in my o	me, dete and place, pinion, death occur	and due to the c	ause(s) and ma ate and place, a	nner as ste and due to t	ited. the cause(s)	
To the vithin o the	Mec	29b. Signature and title of certifier	A Stated.	~	29c. Licens	se number	2	9d. Date signed	d (Month, D	ay, Year)	
- > - 0		> XYY	W. V	~>		0842		4.21	.08	•	
10×1		30. Name en daddress of person who of VAIBHAV · A · I	2000icle	> .		HANOVE	R ST.	BAL	טאוד	IRE MD	
	tate	31. Date filed (Month, Day, Year)	32. egistrar's Sign	nature do	ale .					21230.	
Regis	strar	APR 2220	32. Jegistrar's Sign	~ ~	ren't	-					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 13, 5:24 РМ April Francis Harrison Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) Nov. 15, 1928 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1X M 2□ F Yrs. Utah 262-38-5062 79 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Ex miner must be notified at 1 ☐ Yes 2 No Director Montgomery Village Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20886 19301 Watkins Mill Road United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates 1951 –1953 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within. Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Interior Design Interior Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Carter Miller Frances Price ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a important: if flem 27 is any injury or other traur. P.O. Box 325, Rye, New Hampshire 03870 Carter Harrison/Niece altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April 17,2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of Funeral S hice Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. MO0198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an st, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence Examiner Choking Episode Sequentially list conditions, if any, leading to immediate cause. Each of chart, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-tran Due to (or as a consequence of): P.O. Box 68760, the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? certificate has been signed l rector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by Cerebrovascular Accident with Lasting Paresha 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2√ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 X ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 □ Natural 5 Pending investigation 1:00 PM 1 ☐ Yes 2 ☐ No Choking 4/13/08 2 X Accident 24 hours after death Funeral Director: 28e. Place of injury - At home, farm, street, factory, office determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Restaurant

28f. Location (Street and Number or Rural Route Number, City or Town, State)

#2 Preserve Parkway 2

\*\*Rockville\*\*

\*\*Rockville\*\*

\*\*On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide 29a. Certifier within 24 ho

To the Fun

completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0066896 April 13, 2008

12+1

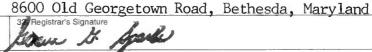
Francis

Miller

State Registrar Matt Leonard, M.D.
31. Date filed (Month, Day, Year)

APR 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

america item 5 per fth 9880 6-6-08 Vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 17, 2008 Virginia L. Martin April 15:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 529 Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex Months Days Hours 1 □ M 2 🕅 F <del>Z-</del>40-8798 June 24, 1928 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 □Yes 217 No Bethesda Maryland | Montgomery Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 7705 Cayuga Avenue 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Non-Profit Elementary/Secondary (0-12) College (1-4or 5+) Service Organization Executive Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Herbert Stanley Dudley Helen Marie Laughton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Dudley Martin / Son 875 Calico Court, Waukesha, Wisconsin 53186 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Apr. 26, 2008 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home/Rockville, Inc M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction hours Due to (or as a consequence of): Coronary Artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of attending physician and for uses the burial-transit Diabetes Mellitus type 2 vears Due to (or as a consequence of): Physician/Medical S for use the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lower gastrointestinal bleeding 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cellulitis of the left lower extremity 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Diabetic foot ulcer 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? aged 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

Q,

**Funeral** 

Director

fshow

d other than "natural", or items 23a or 28a-f shov event, the Wedical Evansing rougher notified at

within 72 hours after

12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r

permit. Pages 1 and 2 should be file Department of Health and Mental HI Important: If item 27 is marked oth any Injury or other traumatic eventany Injury or other traumatic eventany

**Physician** /Medical

Examiner

signed by the a d be detached f

Jas

funeral

the

filled in by

Hospital or Attendi 24 hours after death, Funeral Director: A

within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

MARIES

RAINA

State Registrar

Ί.

31. Date filed (Month, Day, Year)

APR 2 2 2008

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

32. Registrar's Signature

Merendino, Jr., M.D., 10215 Fernwood Rd., #405, Bethesda, MD 20817

D36046

April 18, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:48 AM 04/20/2008 Marjorie J. McNeese 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Our Family Assisted Living Mount Airy Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Months Days Hours Min. 1 □ M 2 🖾 F 345-24-5421 80 06/16/1927 TT. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 1 □Yes 2 TX No MD Frederick Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16350 Camalo Drive 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Specify: white 1 ☐Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John H. Leverenz Ada L. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. J. Michael McNeese son 2416 Fairway Oaks Ct.; Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 04/25/2008 Crownsville, MD Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final END STAGE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No

attending physician and for use as the burial-trans P.O. Box 68760 alleese, Marjoric signed by the a Division of Vital Records, icate has been sig certificate has funeral director, After this Hospital or Attending P 24 hours after death. Funeral Director: After t filled in by the within 24 hours a

To the Funeral D

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

the

death with

filed within 72 hours after

Pages 1 and 2

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ပ

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Mcdiox Examiner must be notified at

and Mental Hygiene. Is marked other than

Department of Health ar Important: If item 27 Is any Injury or other trau

**Physician** 

/Medical

Examiner

25. Was case referred to medical examiner<sup>4</sup> examiner: 1 ☐ Yes 2√2 No 27. Manner of Death

3 Suicide

29a. Certifier

4 - Homicide

31. Date filed (Month, Day,

investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltomy 21204 MD/555W.

State Registrar



DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 2008 oger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country) ay5 hape orien If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days Months 1 M M 2 □ F Hours Pennsylvania 218-40-775 Director 8,194 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director timore MD altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3022 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10Derator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krelyn Louise Mason 3022 Daklorest MD 21234 Hmore -SPOL 20b. Place of Disposition (Name of cometery, crematory or other place)
Evans Funeral Chapel +
Cremation Services - Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-19-08 4 □ Donation 5 □ Other (Specify) torest Itill, MD 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville
18800 Harford Road Pagkville MD 21234 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan; The law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 Tyes 2□ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform Yes 2 certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 200 Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of De After 5 Pending investigation after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir The CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and tile of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who con

Year)

APR 2 2 2008

31. Date filed (Month, Day,

2. Registrar's Signature

Physic	cian	1. Decedent's Name (First, Mid	dle, Last)	Maio	ha	/				2. Date of Dead Month	Day	Year	3. Time of E				
/Med Exam		4a. Facility Name (If not instituti	on, give stre	eet and numb	ber)		4b. City. To	own, or Location	of Death	4	12 4c. Co	2008 unty of Death	3.11	-			
Exam	mer	University of	P .	yland			Page .	Paltimor									
Funera	1	5. Social Security Number	6. Sex			s. last birthday)	If Under 1		r 24 Hrs. Min.	8. Date of Birt (Month, Da	h /, Year)	9. Birthp	place (State or	Foreig			
Directo	r	076-82-3223	· K W	2 F	55	Yrs.				09-13-			istan				
It ow		Usual Residence of Decedent  10a. State 10b. Coun	ty		10c. C	ity, Town or Lo	ocation					1	0d. Inside City	/ Limit			
fled a	ţoţ	MD BAL	TIMOF	RE	BA	ALTIMO	RE						1 ☐ Yes	2 <b>X</b> N			
or 288	Director	10e. Street and Number					10f. Zip Co	ode			10g. Citizer	of What Cour	ntry?				
23a rust b	ral	201 Ball Par						225				kistan					
items ner m	Funeral	11. Marital Status		Armed Force		U.S. 13.	Was Deceden If Yes, specify	nt of Hispanic O Cuban, Mexica	rigin? (Span, Puerto	ecify Yes or No Rican, etc.)	.   14.	Race - Americ Black, White,	American Indian, White, etc.  Pakistanian iness/Industry  Lore )  tate, Zip Code) 21136 Eity or Town, State  1stown, MD				
72 hours after death with the Maryland "natural", or items 23a or 28a-f show dinal Examiner must be notifled at		If Yes, Give  3 □ Widowed 4 □ Divorced   If Yes, Give  Year or Dates:   1 □ Yes 2 ★ No Specify:							<b>/</b> :		Sp	Specify: Pakistania					
atura ral E	ted	15. Decede	ent's Educati	ion		16a. Dece	dent's Usual C	Occupation			16b. Kind	of Business/Inc		-u			
Me a	Completed	(Specify only high Elementary/Secondary (0-12)	<del></del> _	ompleted) College (1-4	4or 5+)	(Give	e kind of work o DO NOT use i	done during mo retired)	st of work	ing			State, Zip Code)  21136				
ntal Hygiene. Id other than event, the M	Con	12th		NA		Man	ager					Store	e				
- 0 5	Be	17. Father's Name (First, Middl Mehr Abdul		5d				I		(First, Middle,		rname)					
th and Mental  7 is marked of traumatic ever	은	Mehr Abdul Majeed  Sory:  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or										04-4- 7:-	. 0 - 1 - 1				
7 is trau		Dr. Javed Sa		,	en lav	ĺ											
f Health Item 27 i other tra		20a. Method of Disposition	arr-	BLOUIEL	20b.	Place of Dispo	osition (Name	of		sterst							
P = P		1 ☑ Burial 2 ☐ Cremation		noval from St	ate		matory or othe										
Departmen Important: any injury once.	a	4 □ Donation 5 □ Other  21. Sign tune of Funeral Service		1 1	Kir	ng Memor		Address of Faci	)4-1:	3-08	Rand	dallst	own,_	MD.			
Depa Impo any is			- 1	Y	0	Ma	arch Fu	meral H	Home	West, I	nc	2.	03				
		G CON		- 1	1-0								MD 21				
		23a, Part1. Enter the disease.	or complicat	tions that cau	ised the dea	Do not en	300 Wat	oash Av	Α.	or respiratory a		alto.					
1.6.		23a. Part1. Enter the risease, shock, or heart fature. Li	or complicat st only one o	tions that cau cause on ead	used the dea ch line.	Do not en	300 Wat ter the mode of	oash Av	Α.	or respiratory a			Approximate Interval Betw Onset and D	/een			
ysician Medical	_	23a. Part1. Enter the Usease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complicat st only one o	Trau	ematic	Brai	300 Walter the mode of	oash Avo	Α.	or respiratory al			Approximate Interval Betw	/een			
		disease or condition resulting in death)	(a	Trau	used the dea ch line. r as a consec	Brai	300 Wat ter the mode of	oash Aving such a	Α.	or respiratory a			Approximate Interval Betw	/een			
Medical caminer		disease or condition resulting in death)	or complicat st only one of	Due to (or	ematic	Brazi	300 Wat in Inje	oash Av	Α.	or respiratory al			Approximate Interval Betw	/een			
Medical caminer		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(a	Due to (or	r as a consec	Bradiquence of):	300 Wat in Inje	oash Av ordyng, suara	Α.	or respiratory al			Approximate Interval Betw	/een			
Medical caminer	Examiner	disease or condition	(a	Due to (or	r as a conse	Bradiquence of):	300 Water the models	Oash Av	Α.	or respiratory al			Approximate Interval Betw	/een			
vsician and springstransit and burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(a	Due to (or	r as a consec	Bradiquence of):	300 Water the models	Cash Av	Α.	or respiratory al			Approximate Interval Betw	/een			
vsician and springstransit and burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	Due to (or	r as a consecutive as a consecutive r a consecutive r a consecu	Brazinguence of):	300 Water the models	Oash Av	Α.	or respiratory al	S WESTERN TAN	and the second	Approximate Interval Betwo	/een			
Medical  water and the purial-transit are as the burial-transit are	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or Due to (or 1) Live birt	r as a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutiv	Quence of):  quence of):  quence of):  anancy tal death 3 [	300 Wat fer the mode of n Zyjo	oash Av	Α.	or respiratory al	S WESTERN TAN		Approximate Interval Betwoonset and D	/een			
Medical  water and the purial-transit are as the burial-transit are	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if afry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a	Due to (or Due to (or 1)	r as a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutive r a consecutiv	Quence of):  quence of):  quence of):  anancy tal death 3 [	300 Water the model of the Control o	oash Av	Α.	or respiratory al	S WESTERN TAN	I. Date of delive	Approximate Interval Betwoonset and D	een eath			
ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	a	Due to (or Due to (or	r as a consecutive as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	300 Wat Ter the mode of Yn Zyjo December 1990	gash Av	S Cardiac	THE PROPERTY OF THE PROPERTY O	went the state of	I. Date of delive	Approximate Interval Betwoonset and D	eath			
gned by the attending physician and in a physician	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or Due to (or	r as a consecutive as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	300 Wat Ter the mode of Yn Zyjo December 1990	gash Av	S Cardiac	Interested by Perfect Land Control of the Control o	guerrant 23d	I. Date of deliver	Approximate Interval Betwoonset and D	eath eath			
been signed by the attending physician and in positions and in position be detached for use as the burial-transit	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions.	a. b c d 23c.	Due to (or Due to (or Due to (or 1   Live bird 4   Pregnar 9   Unknow butting to dea	r as a consector as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	300 Wat Ter the mode of Yn Zyjo December 1990	gash Av	S Cardiac	23e. Did to	23d  bacco use  yes 2 1	I. Date of deliver Month	Approximate Interval Betwoonset and Donset a	ear eath?			
has been signed by the attending physician and in position in the burial-transit in the	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. b c d 23c.	Due to (or Due to (or Due to (or 1   Live bird 4   Pregnar 9   Unknow butting to dea	r as a consector as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	300 Wat Ter the mode of Yn Zyjo December 1990	gash Av	S Cardiac	23e. Did to	23d  bacco use  (es 2   1	t. Date of deliver Month	Approximate Interval Betwoonset and Donset a	eath eath eath vailab			
ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the	a. b c d 23c. tions contrib	Due to (or Due to (or Due to (or 1   Live bird 4   Pregnar 9   Unknow butting to dea	r as a consector as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	300 Wat Ter the mode of Yn Zyjo December 1990	inancy se given in Part	S Cardiac	23e. Did to	23d  bacco use  (es 2   1  syrrmed? 2 Divisor	I. Date of deliver Month  contribute to the No 3 Protection Profession of Contribute autoprior to condeath?	Approximate Interval Betwoonset and Done of the Cause of department of the Cause of	eath eath eath vailab			
certificate has been signed by the attending physician and inspection, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of the condition of	a. b c d 23c.  tions contrib	Due to (or Due to (or Due to (or 1) Live bird 4 Pregnar 9 Unknow butting to dea	r as a consector as a	Province of provin	BEctopic preg	inancy se given in Part	e dardiac	23e. Did to	230  Deacco use  /es 2   1  an 2  ssyrmed? 2 De No	I. Date of deliver Month  Contribute to the No 3 protection of the Protection of the No 1 prior to condeath?	ery Day Y he cause of depably 4  popsy findings a mpletion of ca	eath eath eath vailab			
s certificate has been signed by the attending physician and in particular, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	a. b c d 23c. tions contrib	Due to (or Due to (or Due to (or 1   Live bird 4   Pregnare 9   Unknow butting to dea	r as a consector as a	auth. Do not en Brazinguence of):  equence of):  equence of):  equence of):  equence of):	Get the mode of t	inancy se given in Part  26. Plac  Other:	e dardiac	23e. Did to 1 24a. Was autor performer 5 Pesis	23d  bbacco use  /es 2 1  an 2  reflection of the control of the c	I. Date of deliver Month  Contribute to the No 3 Protection of the Protection of the North Protection	eny Day Y  he cause of de pably 4 100 psy findings a mpletion of ca	ear earnknov			
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  25. Was case referred to mediate examiner? 1   Yes 2   No   No   No   No   No   No   No	a. b c d 23c.  tions contrib rena_( terry  tal  Hos	Due to (or Due to (or Due to (or 1   Live bir 4   Pregnar 9   Unknow butting to dea Liseas Date of (Month, Month,	r as a consector as a	Provinguence of):  and the provinguence of):  an	Get the mode of t	inancy se given in Part  26. Plac  Other:	e ardiac	23e. Did to 1 24a. Was autor performer 5 Pesis	23d  bbacco use  /es 2 1  an 2  reflection of the control of the c	I. Date of deliver Month  Contribute to the No 3 protection of the Protection of the Note autoprior to code at h?  1 yes	eny Day Y  he cause of de pably 4 100 psy findings a mpletion of ca	ear ear nknow			
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. b c d 23c.  tions contributions Due to (or	r as a consector as a	panel Do not en Brown auguence of):  requence of):	Ectopic preg	inancy se given in Part  26. Plac  Other: Work?  1   Yes 2 [	e ardiac	23e. Did to 1 Ves to (Check only o	23d  bbacco use  yes 2 1  an 2  an 2  an 2  an 2  an 2  an 3  sy  ne)  dence 6 [  now injury o  down	t. Date of deliver Month  contribute to the No 3 Protection Profession Coursed Subn Stair	ery Day Y  he cause of de pably 4 100 opsy findings a mpletion of cause of the past of the	ear eath?				
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 2   Yes 2   No   Yes 2	a. b c d 23c.  tions contrib	Due to (or Due to (or Due to (or Due to (or 1   Live bir 4   Pregnar 9   Unknow butting to dea	r as a consector as a	rquence of):  rquence of):	BEctopic preg	grash Aving, such a construction of dying, such a construction of the construction of	e of Deat	23e. Did to 1 Yes  1 Check only of 28f. Location (5) City or 76 201 Ba 1	23d  bbacco use  //es 2   1  an   2  with the control of the contr	t. Date of deliver Month  contribute to the No 3 Protection Protection Substitutes and Substit	ery Day Popsy findings a mpletion of ca	ear eath?			
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 2   Company   Co	a. b c d 23c.  tions contributions Due to (or Due to (or Due to (or Due to (or 1   Live bird 4   Pregnare 9   Unknow butting to dea	r as a consector as a	quence of):  quenc	BEctopic preg	plancy  inancy  inancy  if Other:  Injury at Work?  I Yes 2 [5]  the time, date at the time, date at the time.	e ardiac	23e. Did to 1 Yes  1 Yes  24a. Was autoperfor 1 Yes  28d. Describe Is  28f. Location (c. City or To) 201 Baltimo	23d  bbacco use  (es 2   1  an   2  an   2  check   6    chow injury of the course (s) an of the course (s) and (s) an	Date of deliver Month  Load of deliver Month	ery Day Phe cause of depably 4 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ear eath?				
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unkno	a. b c d 23c.  tions contrib  rena (  terry  tal Hosp  ting Physicial Examiner	Due to (or Due to (or	r as a consector as a	paule Do not en Brown audience of):  quence of):  quence of):  quence of):  quence of):  quence of):  paule of brown audience of brown aud	DOA of 28c.	inancy  26. Plac  Other: 4 North All	e of Death	23e. Did to 1 24a. Was autor performe 5 Resir 28d. Describe 1 28f. Location (3 City or Tov 2 and due to the red at the time,	23d  bbacco use  yes 2 1  an 2  yes yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 3  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  an 4  yes  an 4  an	Date of deliver Month  Contribute to the No 3 Protection of the Protection of the North Protection of	ery Day Y he cause of de pably 4 Po poss findings a mpletion of ca 2 No  No  Tes  A Foote Name  Brook 1  stated, o the cause(s)	ear eath?			
s certificate has been signed by the attending physician and in particular, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. b c d 23c.  tions contrib  rena (  terry  tal Hosp  ting Physicial Examiner	Due to (or Due to (or	r as a consector as a	paule Do not en Brown audience of):  quence of):  quence of):  quence of):  quence of):  quence of):  paule of brown audience of brown aud	DOA of 28c.	inancy  26. Plac  Other: 4 North All	e of Death	23e. Did to 1 24a. Was autor performe 5 Resir 28d. Describe 1 28f. Location (3 City or Tov 2 and due to the red at the time,	23d  bbacco use  yes 2 1  an 2  yes yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 3  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  an 4  yes  an 4  an	Date of deliver Month  Contribute to the No 3 Protection of the Protection of the North Protection of	ery Day Y he cause of de pably 4 Po poss findings a mpletion of ca 2 No  No  Tes  A Foote Name  Brook 1  stated, o the cause(s)	ear eath?			
fler this certificate has been signed by the attending physician and increased for use as the burial-transit in increased for use as the burial-transit increased for use as the burial-transit increased for use as the burial-transit increased incr	Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unknown  Part II. Other significant conditions of the past 12   No 9   Unkno	a. b c d 23c.  tions contrib  rena (  terry  tal Hosp  ting Physicial Examiner	Due to (or Due to (or	r as a consector as a	paule Do not en Brown audience of):  quence of):  quence of):  quence of):  quence of):  quence of):  paule of brown audience of brown aud	DOA of 28c.	inancy  26. Plac  Other: 4 North All	e of Death	23e. Did to 1 Yes  1 Check only of the Control of t	23d  bbacco use  yes 2 1  an 2  yes yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 2  yes  an 3  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  yes  an 4  an 4  yes  an 4  an	Date of deliver Month  Contribute to the No 3 Protection of the Protection of the North Protection of	ery Day Y he cause of de pably 4 Po poss findings a mpletion of ca 2 No  No  Tes  A Foote Name  Brook 1  stated, o the cause(s)	ear eath?			

08-02942 Laura McCray

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 2976

			For State	,	Certi	ficate of	Death					Reg. No.		T- = (0 "		
	Physicia		. Decedent's Name (First, Middle,La	st)							Date of Dea Month		Year	3. Time of Death 0706 hrs		
90.	ব Examir	_	Laura Lorrin	e McCray							Month April 15, 2		nty of Dea			
4		4	a. Facility Name (if not institution, gi	ve street and nur	nber)		4b. City, Town Baltimore		cation of I	Death		40.000	ity oi Dea			
			1818 Division Street				If Under 1		If Under 2	24Hrs	8 Date of B	irth (MM/DD/Y	YYY) 9. B	irthplace (State or Foreign		
	Funeral	15	Social Security Number 6. S 217-22-8210		7. Age (In yrs. las	t birthday)		Days	Hours	Min.			1	country)		
	Director		1	M 2 X F	81	Yrs	3.				March	3, 1927		MD		
	'n		Jsual Residence of Decedent  0a. State 10b. County		10c City T	own or Local	tion							10d. Inside City Limits		
	w any		MD 100. County		Too. Oily, 1	011.1.01.2000	Balt	imoı	ro					1 XX Yes 2 No		
	Maryland 28a-f show d at once.	후					10f, Zip Coo					10g. Citizen o	f What Co	ountry?		
	th the Maryland 23a or 28a-f sho notified at once.	Director	De. Street and Number 1818 Division	Chanak			,		7		Ì					
	th the 23a o notifi				edent Ever in U.S	13 W	as Decedent o	21217		n? (Spe	cify Yes or N	lo- 14. l	USA Race - Am	erican Indian, Black,		
	th wi	Funeral	11. Marital Status  1 Never Married 2 Marrie	Asmod Ec	orces?	If `	Yes, specify Co	ıban, N	Mexican, F	Puerto R	ican, etc.)	,	White, etc.			
	er dea			1 Yes ed If Yes, Give Yea	2 XX No	1	Yes 2XX	No .	specify:			Spe	cify: Bla	ack		
	rs aft ural" mine	화	15. Decedent's Education (Specify	or Dates:	_	16a. Decede	nt's Usual Occ	upation	n (Give ki	nd of wo	rk done	16b. Kind	of Busines	s/Industry		
	2 hou "nat	15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retired to the property of the pro							se retire	d)						
36	than than											mestic	2			
5-0036	lygier bether	ड़े	17. Father's Name (First, Middle, La					18	.Mother's	Name (	First, Middle	e, Maiden Surr	name)			
2	be fill rked rent,	Be	Charles A. Williams Man								J. Bo		City or Town, State, Zip Code)			
27	1 and 2 should be filed within 72 hours after death with the Maryland 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Madical Examiner must be notified at once	은	19a. Informant's Name/Relationship			19b. Mailir										
2	nd 2 sl lith ar m 27 auma		Clifton Lyons	/ Nepnew	Tanh B	lace of Disno	1136 N sition (Name of			Stree	et; <u>Bal</u> Date	timore.	Mary La ition - City	or Town, State		
9	s lar of Heal	- 1	20a. Method of Disposition  1 Burial 2 XXCremation	Removal fr		rematory or o			,							
1	Page ment or lant:		4 Donation 5 Other Spec	ify:		Metro Cr	ematory		(Facility	04/19	2/2008	Caton	sville	Maryland		
Poltimore	permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Mod		21. Sign were of Funeral Service Lic	ensee		100	Name and Ad						-			
			23a. Part I. Enter the disease, or co	Mications that o	aused the death.	Do not enter	38 N. Gi	ying, s	uch as ca	rdiac or	respiratory	re, Mary arrest, shock,	or heart	Approximate Interval		
	Physician ical		failure. List only one cause on	each line.	ve Atheroscle									Between Onset and Death		
r,	<b>xaminer</b>		Immediate Cause (Final disease or condition resulting in death)		a consequence of		alovascolai	Disc	,430							
			Sequentially list conditions,	b												
		le	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence of	):										
	W	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of	·):										
	d d		events resulting in death). Last	d.												
	rou, icate be executed physician and	Medical	UNPENDED	AMENDED												
ç	ate be	Med	IF FEMALE:	23c. If yes,	outcome of pregi				_				ate of deli			
707	ertific ding p		23b. Was decedent pregnant in the past 12 months?	1 Live	birth nant at time of de	- 41-	Fetal death		Ectopic	pregna	ncy	Mo	onth	Day Year		
	that the death certificate by the death certificate by the attending physic detached for use as the bu	Physician	1 Yes 2 No 9 V Unkno			ath 5	Other (Specify	" —				1				
	the d sy the	Ph	Part II. Other significant conditio	ns contributing	to death but not re	esulting in the	e underlying c	ause gi	ven in Pa	ert I.				e to the cause of death?		
ı	Cords, P.O.  Iaw requires that that been signed by	by	Congestive Heart Failu	re							1	Yes 2 N	lo 3	Probably 4 Vunknown		
	dS, equire een si ould b	tec									24a. W	as an utopsv	24b. Wer	e autopsy findings available to completion of cause of		
,	COF law r has b	Completed by					<del></del>				pe	erformed?	deat			
ć	tal KeC iciau: The l certificate l rector, page	ပြီ	OF Management to modical	<del></del>			26	Place	of Death	(Check		33 2 110	, ,			
7	ician: s certi	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatie		- 1	Other <sub>4</sub>		g Home 5	Residenc	e 6 🗸 (	Other: Scene		
?	OF VI ing Physi After this uneral di	<u>P</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time		c. Injur	y at Work	(?	28d. Descr	ibe how injury	occurred			
	on of nding Ph th. r: After t	io io	1 Natural 5 Pendir	g	th, Day,Year)			1 Y	es 2	No						
	DIVISION Of VITAI RECORDS, tall or Attending Physician: The law requiring prise of the dearth.  All Directorarh.  In Just of the funeral director, page 2 should to the funeral director, page 2 should the dearth.	icat	2 Accident Investi	28e Pla	ice of Injury - At h	ome, farm, s	treet, factory, o	office b	uilding, et	tc.		on (Street and	Number	or Rural Route Number, City		
i	DIVISIOR  Sepital or Attent hours after death meral Director: y filled in by the	Certification:	3 Suicide 6 Could determ		1)						OI TOW	m, State)				
	F 2 H		29a. Certifier	sician: To the b	est of my knowled	lge, death oc	curred at the t	me, da	ate and pla	ace, and	due to the	cause(s) and	manner as	stated.		
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Exam	iner:On the basis	s of examination a	and/or investi	gation, in my o	pinion	, death oc	ccurred a	at the time, o	late and place	, and due	to the cause(s)		
	F % F S	₩	29b. Signature and title of certifier						e number					(Month, Day, Year)		
	7		unet "					0.0.1	М.Е.			April	15, 200	o 		
	2		30. Name and address of person v			n 23a)	0		. 45	0400						
				- 1 1 N A 1: 1												
	<i>~</i>		Ana Rubio MD. Assi 31. Date filed (Month, Day, Year)	stant Medica	Registrar's Signat		Street, Ba	altimo	ore, MD	2120						

DHMH 17 Rev 1/2001

Registrar

18,

NADEAU

EVA

41 State Registrar

31. Date filed (Month, Day,

MD

P20556

2008

Ave Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) isbeth

900

32. Registrar's Signature OŘIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	101	partment of Health and Mental Hertificate of Death	ygiene Reg. No. 2008 12979
Physiciar /Medica		2. Date of I Month 4	
Examine	4. Facility Manager (W. a.), with all and a standard and a standar	4b. City, Town, or Location of Death  Kingsville  If Under 1 Year   If Under 24 Hrs.   8. Date of F	4c. County of Death Balto. Co.
Funeral Director	212-28-5238 Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   8. Date of the Months   Days   Hours   Min.   5-19-	Day, Year) -1932  Md.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Evancine is ust be notified at once.	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th  17. Father's Name (First, Middle, Last)  Anthony J. Ostrowski, Sr.  19a. Informant's Name/Relationship (Type. Print)  Gloria Ostrowski Wife  20a. Method of Disposition  □ □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	SVille    10f. Zip Code   21087	Specify: White  16b. Kind of Business/Industry  Auto Sales  Ite, Maiden Surname)  Aber, City or Town, State, Zip Code)  Sville, Md. 21087  20c. Location - City or Town, State  Balto.Md.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of Be Completed by Physician/Medical Examiner.	Due to (or as a consequence of):  Sequentially list conditions, if they had in the introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□ Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  23e. Dia  24a. Wa a underlying cause given in Part I.  26. Place of Death (Check only pert 1 □ Yes  26. Place of Death (Check only pert 1 □ Yes  27. Injury at Work?  M 1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  1 □ Yes 2 □ No  28f. Location City or To  29c. License number	Interval Between Onset and Death 3
5	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Print Drive Ste di	200 Baltimore MD31237
State Registrar	31. Date filed (Month, Day, Year) 2 Registrar's Signature	M	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 015 AM 2008 PATRICIA APRIL CARLA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) CALVERT ST. LEONARD FLORAL COURT 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1□ M 2 F 215-38-5033 Days 65 AUGUST 30, 1942 WASHINGTON DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No ST. LEONARD CALVERT MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20685 USA FLORAL COURT 1042 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL BOOK KEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIRGINIA ALLEN DAVIS JOSEPH CHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / DAUKHTER FLORAL COURT, ST. LEONARD, MD 20685 PAMELA WALKER 6401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANOVES, MD ANOTOMY WIFTS REWISTE APRILDIDOUS 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HANDUKE MD 31076 7522 CONNELLEY DO STEP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumono Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): emphysemo Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury Due to (or as nsequence of): smolling that initiated events

**Physician** /Medical Examiner

and 4

physician

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notifled at

'natural',

7 is marked other than "natural traumatic event, the Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

ို

Examiner

Be Completed by Physician/Medical Medical Certification: To

page 2 should

1 ☐Live birth 2 ☐ Fetal	I death 3 ☐ Ect					23d. Date of d Month	elivery Day	Year
ntributing to death but not resu	ulting in the under	lying ca	use given in Part I.					e of death? 4 ∐Unknowi
					24a. Was an autopsy performed?	prior to death?	o completior ?	n of cause of
			26. Place of De	ath (C	heck only one)			
Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	3 🗆 DO	A Other: 4 Nursing	Home	Residence	6 □Other (Sp	ecify)	
28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury at Work? 1 ☐ Yes 2 ☐ No	280	l. Describe how injur	y occurred		
28e. Place of injury - At ho building, etc. (Specif	ome, farm, street,	factory	office	28f.	Location (Street an City or Town, State	d Number or i	Rural Route	Number,
_	1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown  htributing to death but not resu  Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)	4 □ Pregnant at time of death 5 □ Ot 9 □ Unknown  Intributing to death but not resulting in the under the	1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (spe 9 Unknown Intributing to death but not resulting in the underlying can expense the special of the specia	1	1	Compared to the content of the con	All   Compared to the contribute   Compared	Completion   Com

29c. License number

D0060638

PRINCE

29d. Date signed (Month, Day, Year)

MD 20678

4/18/08

FREDERIUL

Registrar DHMH 17 Rev 1/2001

State

within 24 hours after death.

To the Funeral Director: A
completely filled in by the for To the Hospital To the Func

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

110. HUSPITAL

APR 2 2 2008

Herdons

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

08-02857 Anahi Ordonez Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day April 12, 2008 Madical Examiner 0610 hrs ANAHI ORDONEZ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** 2005 Foreign Country) U.S.A. Months Davs Hours Min. Director 694-01-8840 3 February 2 X F M Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No 23a or 28a-f show Maryland Prince George's Laurel Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9023 Contee Road # 102 20708 United Stated Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Yes Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. 1 X Yes 2 No specify: Guatemalan 3 Widowed If Yes, Give Year 4 Divorced Specify: American Indian other than "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 NONE NONE 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) it: If item 27 is marked other traumatic event, Be JORGE MAURICIO ORDONEZ ORALIA LOBOS LOPEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9023 Contee Rd # 102 Laurel, JORGE MAURICIO ORDONEZ (father) Maryland, 20708 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Cemetery: Progreso 1 X Burial 2 Cremation 3 X Removal from State 04/23/08 Jutiapa, Guatemala Department o Donation 5 Other Specify 22. Name and Address of Facility Santa Cruz Funerales Latinos, Inc 1. Signatur of Funeral 600 Kennedy ST, NW. Washington, D.C. 23a. Part I. Enter the the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and ise e, or com lications **Physician** failure. List only one cause on each line 'Medical Death a. Asthma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED the attending physician hed for use as the burial -AMENDED #23a.27.penME.g880 6/5/08 TI The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by à 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has h autopsy performed? death? ✓ Yes 2 certificate 1 🗸 Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: examiner? Other; ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 2 Inpatient 1 V Yes No 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.F April 13, 2008 30. Name and address of per on who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra APR 2

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar DHMH 17 Rev 1/2001

State

3900 LOCH RAVEN BOULEVARD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MILLER, MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:09/ M April Kochelle 10 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Hospital Baltimore Bultmore 06 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 217-66-4654 9-19-1957 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1Yes 2□No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced las Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working \_life\_ DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should nent of Health and Men ပ္ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 1-10.MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Burial 2 □ Cremation 20c. Location - City or Town, State Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arry themias 15 MINULES Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5-408 Atherosolomic heart dispure Sequentially list conditions, if any, leading to mine distocause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed i / Due to (or as a consequence of): that initiated events resulting in death) Last the attending physician and Division or Vital Records, P.O. Box 68760, 244 commany scents placoment Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by picheles mollihu, periphoni avieno 1 ☐ Yes 2 No 3 Probably 4 Unknown disease, Bilabout toos amputeton 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 autopsy performed? on Hamoelrulysis 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Vcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D304194 4-11-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo alves 7/6 maiden chaire lane sure 302 Calensville OK DESHIND

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Page

ORIGINAL

32. Registrar's Signature

08-03060 Danny Andre Plar	1	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death				
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death				
Medical Examin		Danny Andre Plante   Month Day Year April 19, 2008   1937 hrs				
<b>X</b>		4a. Facility Name (if not institution, give street and number)  Highway 108 & Viewland Drive  4b. City, Town, or Location of Death Damascus  4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 215-74-8395   1   X   M 2   F   F   44   Yrs.   1   1   1   1   1   1   1   1   1				
		Usual Residence of Decedent				
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits				
land f sho	₫	Maryland Montgomery Laytonsville 1 Yes 2 X No				
Mary r 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?				
th the 23a o	إة	7417 Brink Road 20882 United States				
ith wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married Armed Forces?  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolling Forces)  14. Race - American Indian, Black, White, etc.				
er dez		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Specify: White				
irs aft ural"	<u></u> ≧⊦	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Industry				
72 hou	ᆶᅡ	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)				
036 ithin ne.	Completed	12 President/CEO Dry Wall Company				
5-0 lled w Hygie I othe		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)				
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medica	å	Joseph G. Plante Simone G. Roy				
D 2 should and M 7 is m	]٩	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Jennifer D. Plante/Wife  7417 Brink Rd., Laytonsville, MD 20882				
, MD and 2 sho ealth and tem 27 is traumati	H					
Ore ges 1: t of H : If it		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Removal from State Gate of Heaven  20c. Location - City or Town, State  April 24,  20c. Location - City or Town, State  Silver Spring, MD				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	A Donation 5 Other Specific CAMATARY				
		M01346 Rockville, Inc. 300 W. Montgomery Ave. Rockville, MD 20850				
Physician 'Medical		23a. Part T. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and				
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  Multiple Injuries  Death  Due to (or as a consequence of):				
	- 1	b				
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
1.	탈	Consease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
D. 5 _ E	ш	d.				
- 0 -5.5	Physician/Medical	UNPENDED AMENDED				
68760, certificate be noting physici ise as the buri	ŽĮ.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of Month 23d. Date o				
68 certifi nding	ļä,	past 12 months?				
30x death ne atte	Si	1 Yes 2 No 9 Unknown 5 Other (Specify) 9 Unknown				
P.O.	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown				
ds, equire	Completed	24a. Was an 24b. Were autopsy findings available				
COT law has t	립	autopsy prior to completion of cause of performed? death?				
Re : The ificate f, pag		1 ✓ Yes 2 No 1 ✓ Yes 2 No				
25. Was case referred to medical examiner?  15. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5						
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	읽	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  Driver of motorcycle vs auto collision				
Sior Vittend death ctor:	Certification:	2 🗸 Accident Investigation				
Divis	Ě۱	3 Suicide 6 Could not be determined (Specify) Major Poad / Highway (Specify) Major Poad / Hig				
spi Jou	<u>3</u>	4 Homicide 1970 Wajth Nodu / Fightway 1980 & Novince British Demission To the best of my knowledge death accounted at the time date and place and due to the equación and manner as elected				
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	io I	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
To wit	ا ف	and manner stated.				

20

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)
APR 2 2 2008

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 20, 2008

OCME

my

Assistant Medical Examiner

7. Age (In yrs. last birthday)

10c. City, Town or Location

79

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Min.

Cheverly

Months Davs

3. Time of Death

11:45 A

10d. Inside City Limits 1 ⊈Yes 2 □ No

Day

4c. County of Death

8. Date of Birth 1928 9. Birthplace (State or Foreign (Month, Day, Year)

Prince George's

Black, White, etc.

Federal Government

29d. Date signed (Month, Day, Year)

Specify:

Concord N.C.

Black

April 13,2008

September 24

Month

**Physician** /Medical **Examiner Funeral** 

Margie

10a. State

5. Social Security Number

206-22-0094

Usual Residence of Decedent

Porter

4a. Facility Name (If not institution, give street and number)

10b. County

Prince George's County Hospital

Director 3a or 28a-f show t be notified at 23a

Director Maryland | Prince George's Capital Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 20746 United States 1225 Capital Heights Blvd. 1 and 2 should be filed within 72 hours after death v health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Twelth None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mae Little Henry B. Barber ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other t Algie S. Porter/Husband 1225 Capital Heights Blvd., Capital Heights MD 20746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 19. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Decation 5 ☐ Other (Specify) Ft Lincoln Cemetery 2008 21. Signature | Funeral Pervice License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pres monio /Medical Due to (or as a consequence of): Examiner Forline Genotic Sequentially list conditions Due to for as a consequence of: Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial attending pt for use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Jusean page 2 certificate has 25. Was case referred to medical examiner? funeral director, Be Hospital: 1 Yes 2 **1 1** √0 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier (Check only one) and manner stated. within 24

Brentwood, Maryland 22. Name and Address of Facility Frazier's Funeral Home Inc 389 Florida Ave NW Washington DC 20001 Approximate Interval Between Onset and Death 4 days 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 100 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

Daniel Alexande

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital

29c. License number

00052815

Drive Cheverly ND 20785

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 4:40 PM **Physician** Elizabeth Champlin Peterson April 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 306 Overlook Drive Baltimore Timonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-06-1927 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 81 Director 474-30-2408 Rhode Island Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Baltimore Timonium Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Overlook Drive 21093 U.S.A. Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. f and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ₩ Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William James Champlin Ada Whitford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Peterson/Son 321 Stratford Rd., Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-2008 Hilltop Service Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd.. Towson, MD .21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events burial-tran Division or Vital Records, P.O. Box 68760 resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗶 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifie of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** PFEIFER 4.50 AM ALMA 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** GLEN BURNIE SMMA BATTMORE WASHINGTON ARUNDEZ HOSP. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10-19-1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔼 F 214-44-9295 87 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 TNo Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Scotts Manor Drive U.S.A. 21061 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or iter 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Baldwin Agnes M. Cutler 19a. Informant's Name/Relationship (Type. Print) daughter/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. 235 Scotts Manor Drive; Glen Burnie, MD 21061 Mrs. Linda Wojciechowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-21-2008 Baltimore Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave SW; Glen Burnie, MD 21061 NO1357 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE MALMUTRITION **Physician** 2YAQ /Medical Due to (or as a consequence of): **Examiner** MAJOR DEPRESSION MONTAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death, To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 10059190 Honoul mo KPRIL 17 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAFFOE-BONNIE BACTIMORE WASHINGTON MEDICAL 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 2 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Richard Joseph Prkna Month Year **Physician** 7:00 A 114 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospita sedale imore 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. Marchay 29, 1936 213-32-8623 1 **3** M 2 □ F 72 Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f sh notified MD Baltimore 1 ☐ Yes 2XINo Essex Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 619 Dorsey Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural', or items dical Examiner mu 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental William J. Prkna Helen Pruchniewski ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Keller 946 Middlebrough Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus 4/23/08 Baltimore MD 20a. Method of Disposition Department of Important: If It any injury or conce. Burial 2☐Cremation 3☐Removal from State 5 ☐ Other (Specify) 4 □ Donation uneral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hydropneumothora Dx to (or as consequence of): /Medical Examiner ight Upper Dusto (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Lung Cancer IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes ertension, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 ☐ Yes certificate 2 No 2 No Hospital or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending ours after death. neral Director: Af filled in by the fur 1 □ Yes 2 □ No investigation 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Prkna, Richard

DHMH 17 Rev 1/2001

Dr. Navara Centola. MD, 9000 Fr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive, Baltimore MD, 21237

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of N	laryland / Depa Cer	artment of H			giene Reg. No. 20(	18 12989
			Decedent's Name (First, Middle, Last)	2		···	2. Date of Dea	ath	3. Time of Death
	Physic /Medi		Itnita	ra	5CO		13pril		ob 1437 M
4	Examir		4a. Facility Name (If not institution, give street and number The Johns Hopkins Hospital	)	4b. City, Town, or <b>Baltimore</b>		Death	4c. County of I	Death
	Funeral	2		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min (Month, Day	(Year)	. Birthplace (State or Foreign Country)
	Director		212-30-0023	7.4 Yrs.			Jan 1	1934	PA
	aryland show f at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			<del> </del>	10d. Inside City Limits
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	Director	MD Baltimore	Ess	ex				1 ☐ Yes 2 🔀 No
	ith th	Dire	10e. Street and Number		10f. Zip-Code		1	10g. Citizen of Wha	t Country?
	s 23a	eral	59 Wiltshire Road		212			USA	
	ter de	Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Deceder Armed Forces 1 Yes 24	? 13. V	vas Decedent of Hi f Yes, specify Cubar	spanic Origin n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc.
21215-0036	72 hours after natural", or ite Ilcal Examiner	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: [	Nhite
5-0	72 hc natur ilical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa	uring most o	f working	16b. Kind of Busin	ness/Industry
121	within lene. than " he Med	ğ.	Elementary/Secondary (0-12) College (1-4 or	5+) life. E	oo NOT use retired) ims Exan			Monumen	ital Ins.
	l be filed within 72 h ntal Hygiene. sd other than "natu event, the Medical	ပိ	10 t h 17. Father's Name (First, Middle, Last)	CIA	IIIS EXAI		s Name (First, Middle,	Maiden Surname)	
Maryland	should be filed withir and Mental Hygiene. marked other than matlc event, the Me	To Be	Joseph Corr				zabeth Ge	· ·	<b>S</b>
ary	2 should and Miles is and Miles		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number	or Rural Route Numbe	r, City or Town, Sta	ite, Zip Code)
	1 and 2 Health (sem 27 l		Sandy Mendoza /daught	er 24	00 Pinev	ville	Crest Co	ourt Ode	enton MD
ore	Pages 1 nent of H tnt: If Iten ury or oth		20a. Method of Disposition 1 □ Purial 20 / Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crem Meadowr	sition (Name of natory or other place	9)	Date / 2.1 / 0.0	20c. Location - City	
Baltimore,	보 된 원 등		4 Donation 5 Other (Specify)  21. Signature of paneral Service Licensee	h	. Name and Addres		/21/08	Baltimo	
Ba	Deparation once.		VIIII FOR	1.0			300 Mace eral Home		Salto. MD
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ente	er the mode of dying	g, such as ca	ardiac or respiratory an	rest,	Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition		ystem !	en il	10		Onset and Death
	/Medical		requiting in death)	s a correquence of):	1011111	iana			De Civiys
	Examiner	_	Sequentially list conditions, b. Carch.		25+				2 days
Г	ed sit	nin	cause. Enter Underlying	s a consequence of).	acia di	( and c	2		110000
•	xecute and al-tran	Examiner	that initiated events c.	s a consequence of):	ery an	rast			yeurs
8760,	icate be executed physician and s the burial-transit	edical	d	<u>.</u>					
189	tificat ig phy as th	Med	IF FEMALE:						
Box	th cer endin	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom	2 Fetal death 3	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
Э. В	that the death certific of by the attending pi detached for use as	Physician/M	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	Other (specify)			World	Day roar
P.O.	that the	y Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
Records,	The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	ed by					1 Ye	es 2 No 3 🛭	☐ Probably 4 ☐ Unknown
Ö	aw requ s been 2 shou	olete					24a. Was a		re autopsy findings available
æ	The lay te has bage 2	Completed					— autops perforr 1 □ Yes	med? dear	r to completion of cause of th?  Yes 2 □ No
/ita	sician: Th certificate irector, pa	Be	25. Was case referred to medical examiner?				Death (Check only on	е)	
of Vital	Physic this ce ral dire	၉	1 ☐ Yes 2 No Hospital: 1 Inpat			4 L Nursir	ng Home 5 - Reside		Specify)
UC C	Ing P	ion:	27. Manner of Death  1. Natural 5 ☐ Pending (Month, Discounties)  (Month, Discounties)	ury 28b. Time of lnjury	28c. Injury Work? M 1 7	?	28d. Describe ho	ow injury occurred	
Division	I or Attending after death. Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm, stre		es 2 No	28f. Location (S	treet and Number of	or Rural Route Number,
Ö	after Direc d in b	Certification:	4 ☐ Homicide determined building, e	tc. (Specify)	,		City or Town		a riara riodic riamosi,
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (check only one) (Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or inv	occurred at the tim estigation, in my op	e, date and p inion, death	place, and due to the o occurred at the time, o	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
	o the vithin to the comple	Mec	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (M	Ionth, Day, Year)
			> Khtt Winson an		Res-	000		April 1	7.1008
	7,		30. Name and address of person who completed cause of	death (Item 23a) (Type, I	Print)				-1-1-0
	Q		KAH EMEN	raria Signatura	150 11	60	00 North Wol	fe St, Balti	more, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 2 2008	ar's Signature	W				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Marie Teresa Potter April 15, 2008 2:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dulaney Valley Assisted Living Baldwin Baltimore if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 Director 217-05-3532 89 9, 1918 Aug. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director Maryland | Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 964 Chesney Lane 21014 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23s any Injury or other traumatic event, the Medical Examiner must gonee. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify 9 Specify. 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John (unk) Lang Mary E. Snyder မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1548 Jarrettsville Road, Jarrettsville, MD 21084 ace of Disposition (Name of Date 20c. Location - City or Town, State William A. Potter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 4-19-08 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. (usa 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio pulmonari **Physician** /Medical Due to (or as a consequence of): Examiner Cequentially list curditures, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician as use IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Inpatient this within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Living 1 tural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

31. Date filed (Month, Day, Year) State APR 2 2 2008 Registrar

29b. Signature and little of certifie

3

34

er Registrar's Signature

عبر (Type, Print) death (Item 23a) (Type, Print)

Mi

29c. License number

318

Robert

Lisle,

M.D.

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 299 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 10:07 AM April 17, 2008 Bernard Edward Posluszny 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Apr. 21, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 1X M 2 ☐ F 219-28-1804 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 608 H. Churchill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2/2 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Head Appliance Technician Gas & Electric Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tillie (nmn) Bernard (nmn) Posluszny Sass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camile A. Posluszny / Wife 608 H. Churchill Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-18-08 Towson, Maryland 21 Signature of Funerial Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. art1. En er the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART PAILURE Due to (or as a consequence of): HEART DISEASE ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery ctopic pregnancy Day Year Other (specify) ng in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

δ

Completed

Be

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

72 hours after death with the Maryland

in and 2 should be file.

Health and Mental Hem 27 Is marked others.

permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked 1 any injury or other traumatic ew once.

10:07

Baltimore,

68760

o

Records,

Division or Vital or Attending Physician:

Physician/Medical þ Completed Be 7 Certification:

Medical

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □E 5 □ C
art II Other significant condition	e contributing to death but not resulting in t	he unde

ACUTE SEPTIC ARTHRITIS

URINARY TRACT INFECTION

1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation Natural 2 ☐ Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Achrew Moustows 29c. License number

29d. Date signed (Month, Day, Year) APRIL 17, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWHKOWSK! MD 35 FOLFORD AND BEZ AIR, MOZICIL

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

within 24 hours after To the Funeral Dire

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 1.574 PAMELA JEAN ROBINSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JULIN PSURNIE ANNE ACTIMORE LOPERITURGION MEDICIAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
MAR 3, 1957 6. Sex 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1□M 2XX Months YORK, 51 176.48.5371 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 570 NOLVIEW CT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 DIETICIAN BALTIMORE WASHINGTON MED. CNTR. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be ပ DONALD BURGER MARY MALLARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 an Department of Healt Important: if item 27 any injury or other tra RICKY ROBINSON HUSBAND 570 NOLVIEW CT., GLEN BURNIE, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **bAYYIEW CREMATORY INC.** APR. 23, 2003 BALTIMORE, MD 21. Sign Funeral Service Li 22. Name and Address of Facility FINK FUNERAL HOME, P.A 426 CRAIN HWY. S., GLEN BURNIE, MD CRECORY V FINK M01148 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or edition resulting in death) How-Snote CER LUNG METARTIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transit Due to (or as a consequence of): 68760 Physician/Medical as Вох IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 performe 2 No Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29c, License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MD W

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, lear)
APR 32 2008

Use

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State	e of Ma	arylan		artmer <i>rtificat</i>				lental Hy	giene Reg. No.	008	12	993
			Decedent's Name (First, Middentification)	fle, Last)								2. Date of De			3. Time	of Death
	Physici /Medi		RUBY FRANC									Month	Day 6	200		10 PM
	Examir	ner	4a. Facility Name (If not institution HARFORD ME			דαי.				Location				ounty of Dea	th	
	Funeral		5. Social Security Number	6. Sex	7. Ag		ast birthday)	If Under	r 1 Year		r 24 Hrs.	8. Date of Bir	th	9. Bir	hplace (State	or Foreign
	Director		215-34-6886	1 □ M 2 🖾	F	70	Yrs.	Months	Days	Hours	Min.	Feb. 9	, 193	8 Mair	yland	
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у		10c. City	, Town or Lo	cation			<u> </u>				10d. Inside	City Limits
	Many a-f eh	tor	Maryland Harfo	rd		Hav	re de	Grace	Э						¥ <b>∑</b> Ye	s 2 No
	or 28	Director	10e. Street and Number					10f. Zip		•			•	n of What Co	ountry?	
	eath v	Funeral	601 Lewis St		Decedent I	Ever in U.	S 13 V		21078		rigin? (Sp	ecify Yes or No	USA - 14	Race - Ami	ncan Indian.	
و	after d		1 ☐ Never Married 2 ☐ Ma	rried 1 🗆 Y	d Forces?		li li	f Yes, spe	cify Cuba	in, Mexica	an, Puerto	Rican, etc.)		Black, Whi		
/O 21215-0036	72 hours after death with the Maryland naturel; or iteme 23e or 28e-f ehow dical Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorce	d Year	s, Give or Dates:			1 🗆 Yes		Specify	/: 			oecity:	White	
\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	n net	plete	(Specify only high				16a. Deced (Give life. L		ork done d	du <i>rina</i> mo	st of work	ing	16b. Kind	of Business	'Industry	
1C	giene.	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4or 5	)+)	Fact	ory V	Worke	er			Pla	stic M	anufac	turer
[7]	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Importants if time 27 is marked other than "naturel; or items 23a or 28a-1 show eny injury or other traumatic event, the Madical Examiner must be notified at once.	Be	17. Father's Name (First, Middle	_								(First, Middle		ımame)		
2	Should nd Mei marki	ဥ	Booker Lee D		)		19b. Mailin	a Address	s (Street a			ee Grac		own. State.	Zip Code)	
	and 2 selth ar		Kenneth Lee	Rockwell	. / Sc	on		-				re de G				
08	ges 1 and He man or oth		20a. Method of Disposition 1 ☑XBurial 2 ☐ Cremation	3 □Removal f	rom State	C	lace of Dispos emetery, cren	natory or c	other plac			Date			Town, State	
16/08	it. Pagintment:		4 Donation 5 Other (	Specify)		Hig	hview			1				ston,	Maryla	ind
/ Ba	Depa fmpo eny to		21. Signature of Euneral Service	lig								me, P.A d, Abin		Marvl	and 21	009
J			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications to st only one cause	hat caused on each lir	the death									Approximation Interval Br	ate etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Ur	em	,	DW	a						Onset and	Death
	Examiner			Du	e to for as	a consequ	ience of):	, ack	٨.							
	it d	ner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying	b	o to (or as	onsequ	uence of):	000.		. 0						
M	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	e to (or as	a consequ	ience of):	Jak	ta	ulu	رمو					
8760.	e be es sicien e buria	dlcal E			0 (0) 20		301100 017.									
9	as a	Medic	IE ECMAN C.	U												
Box	law requires that the death certific as been signed by the ettending p 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 DL	, outcome ive birth	2 Fetal	death 3	Ectopic p		,			230	d. Date of de Month	ivery Day	Year
>0	0 0 0	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		regnant at Inknown	time of de	eath 5	Other (sp	oecify)						,	
S. G.	The law requires that the law requires that the late bas been signed by the bage 2 should be detache	oy Pr	Part II. Other significant condit	ions contributing	to death bi	ut not resu	ulting in the ur	nderlying o	cause give	en in Part	l.	23e. Did t	obacco use	contribute to	the cause of	death?
X Dro	require een sig nould b	ted										1 🗆 '	Yes 2⊡i	Vo 3□P	obably 4	[Unknown
NEII, RU	has b	Completed			<del></del>							24a. Was autop	an osy ormed2	24b. Were a prior to death?	topsy finding completion of	s available cause of
1 E	ician: Th certificate rector, pag	မ င	25. Was case referred to medic	al						oc Di-	V -4 D4	1 Yes	2 No		2 1 No	
\(\frac{1}{2}\) \(\frac{1}{2}\)	Physician: this certifical	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hoepital:	1 Inpatie	nt 2 🗀 !	ER/Outpatien	t 3 🗆 D0	Oth	05		n <i>Check only o</i> me 5 ☐ Resi		Other (Sne	cifu)	
KWE!	ding Phys n. After this funeral di	T :uo	27. Mann of Death 1 Natural 5 □ Pend	28a. C	ate of Injui Month, Day		28b. Time of Injury		28c. Injun Work			28d. Describe			ony)	
RCK	Attending r death. octor: After by the fune	Icatl	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	tigation I not be	Place of Inju	ını - At ho	me, farm, stre	M act factor		Yes 2□		28f Location /	Ctroot and A	lumbor or D	m / Davis Alv	
à à	al or A sefter f Direct d in by	Certification:	4 Homicide deten	mined 200. E	uilding, etc	. (Specify	() ()	eet, lactor	y, onice			28f. Location ( City or To	wn, State)	VUITIDET OF A	TIAL HOULE IVU	rnoer,
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To I Examiner: On the	o the best of he basis of manner sta	examinat	wledge, death ion and/or inv	occurred estigation	at the time, in my of	ne, date a pinion, de	ind place, ath occurr	and due to the ed at the time,	cause(s) ar date and pl	id manner a ace, and du	s stated. to the cause	(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifi		/			29	c. License	e number	-0		29d. Date s	igned (Mon	h, Day, Year)	
			) Ja	y of	nl				D	65	40	3	4	1161	08	
	V		30. Name and address of person Tariq Iqbal, N						o Dr	1570	Rol	Air, M	2101	Λ		
	Sta	te	31. Date filed (Month, Day, Year APR 2	2000	32 Registra	ar's Signat	Lyro for	APCOUNT	. DI	1,6,	101	TATE IN	2101			
	Registr		APR 2	S ZUUS	Contra	U X	F Ago	and I								

1	-	For State Regis	stra

12994

			Registrar		Cei	rtificate of	Death		Reg. No.			
57	Dhusis		1. Decedent's Name (First, Middle, L	ast)				2. Date of D		Vaar	3. Time of Death	
Article Services	Physici /Medi		Charles	Ricke	tts			April	Day	Year 2008	16:55 M	
	Examir		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Deat			County of Death		
			Greater Baltimore	o Modical Conto	r	Towson			IR:	altimore		
*	Funeral			Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		olace (State or Foreign	
100	Director		219-28-1867	12M 2DF 74	Yrs.	Months Days	Hours Min.	- I	ay, Year)	Cour	ntry)	
			Usual Residence of Decedent	1 1		L		Iteb 10	,1955	+ Inar	yland	
and	at ow		10a. State 10b. County	10c, Cit	y, Town or Lo	cation				1	Od. Inside City Limits	
Man	f sh	ō	200		0.						1 ☐ Yes 2 ☑ No	
the the	28a- notif	Director	10e. Street and Number	more	Dal	10f. Zip Code			10a Citiz	en of What Cour		
with	a or		2.2			101. 21p 00de			Tog. Oniz	en or what cour	ny:	
ath	s 23 nust	Funeral	2 West Elm	Huenue	0 1	1 2/2	206			0217		
er de	tem ner n	nu	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or N to Rican, etc.)	lo- 1	<ol><li>Race - Americ Black, White,</li></ol>		
36 aft	o in	by F	1 Never Married 2 Married	1 ☑Yes 2 ☐ No If Yes, Give		1 □ Yes 20亿 No	Specify:			Specify:		
	L A	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						white		
<b>215-0036</b> thin 72 hours af	dca dca	ete	15. Decedent's E (Specify only highest g	Education rade completed)	i (Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kin	d of Business/Ind	dustry	
<b>7</b> i	an e	du	Elementary/Secondary (0-12)	College (1-4or 5+)	0	DO NOT use retired	•				6. 1	
Z M	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene.  7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Ö			Cons	truction	n		115eth	nlehem	Steel	
Ē 9		17. Father's Name (First, Middle, Las	t) (1)			18. Mother's Nar	ne (First, Middl	e, Maiden S	Surname)			
<b>Maryiand</b> d2 should be file		Charles Walt	na.	a Mc Dade								
g Spo		Town, State, Zip										
, <b>M</b>	alth a 27 B 27 B r tra	Patricia A. Ricketts - spouse 3 West Elm Avenue Baltimore mb										
ନ୍ <sub>ଳ</sub>	エッチ	1	20a. Method of Disposition	1 20b. P	lace of Dispo	sition (Name of		Date		ation - City or To		
Baitimore, permit. Pages 1 a	Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 [	□Removal from State Evo	emetery, crei	natory or other place	e) 4 2	0-08			,	
בַ בַ	rtan njur		4 □ Donation 5 □ Other (Spec	(Crem	ntons	arrices-Bel	1Air 1-2		Lore	st Hill 1	Marylanc	
er a	Departi Importa any inj		21. Signature of Funeral Service Lice	nsee	E	Name and Address	ss of Facility	Cremat	non Se	rvices - Pa	rkuitte	
			Slace &	Mach	188	300 Harfo	rd Road	Parkvill	eme	21234		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death y one cause on each line.	n. Do not ent	er the mode of dyin	ng, such as cardia	or respiratory	arrest,		Approximate Interval Between	
Pr	ysician		Immediate Cause (Final disease or condition	Dografination	Tilate						Onset and Death	
1	Medical		resulting in death)	a. Pospiratory  Due to (or as a consequ		<u> </u>					IMMEDIATE	
E	kaminer			Prof Starre I	una Di	G:33G6					YEARS	
100		ē	Sequentially list conditions, if any leaf of the cause. Enter Underlying Cause (Disease or injury	b. End Stage L	iende offic	accae					IEARO	
rted	is A	Examiner	Cause (Disease or injury	Ashostosis							YEARS	
, xec	al-tra	ха	that initiated events resulting in death) Last	c. Asbestosis  Due to (or as a consequ	uence of):						ILARD	
Pe e	iciar buri									İ		
DB/DU	phys	dic		▲d								
	ending physician and cuse as the burial-transit	n/Medical	IF FEMALE:	00-1/								
ء پ	ttend or us		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	incy Ideath 3□	Ectopic pregnancy	,		23	3d. Date of delive	*	
. 0	he a	sic	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)				Month	Day Year	
OrdS, P.O	been signed by the attractions should be detached for	Physicia	9 ☐ Unknown									
Stha	gned e de	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?	
COLOS, w requires t	in sig uld b							1 🗆	Yes 2	] No 3 ☐ Prob	ably 4 🗷 Unknown	
law re	shor	Completed						24a, Wa	0.00	Odb Mass sute	and findings and labor	
The la	has ge 2	d L						auto	opsy formed?	prior to cor death?	psy findings available mpletion of cause of	
	icate , pa								2 □ No	1 X Yes	2□ No	
Or Vital Physician:	יר After this certificate has funeral director, page 2 :	Be	25. Was case referred to medical examiner?	Licenitele		1.	26. Place of Dea					
Physi	this c	2	1 ☐ Yes 2 ☑ No		ER/Outpatien	t 3□ DOA Othe	er: 4 Nursing H	ome 5 ☐ Res	sidence 6	□Other (Specify	v)	
orion P ding P	mera	ation:	27. Manner of Death 1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at k?	28d. Describe	how injury	occurred		
<u> </u>	e t. a	≝	2 Accident investigation				Yes 2 □ No					

To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Division

State Registrar

Medical Certification

2 Accident

3 ☐ Sulcide 4 ☐ Homicide

29a. Certifier

29b. Signature and title of certifier

29c. License number MO D38352

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 04/17/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

GBMC 6701 N. Charles Street; Baltimore MD Beth R. Schwartz, M.D. 31. Date filed (Month, Day, Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

APR 2 2 2008

6 ☐ Could not be

determined

08-02858		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Larry D. Rhodes		State of Maryland / Department of Health and Mental Hygiene
	R	- For State Centificate of Dealin Reg. No.
Physician		1. Decedent's Name (First, Middle,Last)  Month Day Year 1010 hrs
Medical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
wy.		946 Montpelier Street  Baltimore
		Mary 1997 Annual Mary 24 Hours 24 Hours 24 Hours 25 Date of Birth/AMA/DD/WWW 9 Birthplace (State or
Funeral Director	- 1	Months Days Hours Min. (/ C. 10-1
Director		
ny		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
No 43	.	Md N/a Baltimore 1 Hes 2 No
rylane a-f sh	황	10e, Street and Number 10f, Zip Code 10g, Citizen of What Country?
or 28	Ĭ.	946 Manterilier St. 2/218 U.S.A.
15-0036 filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show i, the Medical Examiner must be notified at once.	Funeral Director	11. Marial Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
item ath v	<u></u>	1 Never Married 2 Married Armed Forces? 1 Yes 2 No  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.
		3 Widowed 4 Divorced If Yes 2 No specify: Specify: Specify: Black
urs af tural	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
i 72 ho a "na	et-	Flementary/Secondary (0-12) College (1-4 or 5+)
036 ithin	립	12 Guard Security
5-0036 led within 7 Hygiene. other than	3	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
, MD 21215-0036 and 2 should be filed within 72 hours after ealth and Mental Hygiene. tem 7 is marked other than "natural", traumatic event, the Medical Examiner.	al	John H. Phodes  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AD 212. 2 should be h and Menta 27 is marke	2	1/ / / / / / / / / / / / / / / / / / /
MC Id 2 sl Ilth ar m 27		Date   200   Location City or Town State
s lan		200. Method of Disposition (verme of Disposition (verme) (verm
More Pages 1 a nent of He ant: If its		1 UBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Garrison Forest Vit Cem. 4-25-2008 Bulto led.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other traumatic event, the Med		4 Donation 5 Other Specify: Garrison Forest Vit Cem. 4-25-2008 Salto Ind.  21. Signature of Funeral Service Licensee.  22. Name and Address of Facility  Carifon C. Jought Funeral Service P.A.
<b>0</b> 80 E.E		1 / Mchilla C. William C. William A. Billiam A.
Physician		23a. rart i. Enter the disease, or complications that secused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
/ /Medical caminer		Immediate Cause (Final disease a. Narcotic Intoxication and Alcohol Use
4 (0.1111)	- 1	or condition resulting in death)  Due to (or as a consequence of):
	اير	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Ē	cause. Enter Underlying Cause
11/5	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
of Vital Records, P.O. Box 68760, fing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transis.	g	d
be ex incian	gi	X UNPENDED 23a,27,28a-f per ME g878 4/25/08 amh
68760, certificate be nding physici	hysician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year
68 certif nding ise as	틢	past 12 months?  1 Live birth 2 Fetal death 5 Other (Specify)
Box e death c the atten	ysic	1 Yes 2 No 9 Unknown g Unknown
O. F. hat the ed by the etached	₽.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
P. es tha	ğ	1 Yes 2 No 3 Probably 4 V Unknown
ds,	ee	24a. Was an 24b. Were autopsy findings availab autopsy prior to completion of cause of
COT law has be 2 sh	Completed	performed? death?  1 Yes 2 No 1 Yes 2 No
Re i. The		
ician ician	å	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reads.  ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burity.	မ	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
n of ing h Aft	ö	1 Natural 5 October (Month, Day, Year)
Division ospital or Attendin hours after death. meral Director: A	ertification	2 Accident Investigation FNO 4/12/05 FNO 10-000 fine building etc. 128f Location (Street and Number or Rural Route Number, Ci
Divi	Ę	3 Suicide 6 A Could not be control of the could not be determined (Specifyland 1) 1
Ospit hour	ပ	29a. Certifier a Contificing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) PMedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To To To Com	Wed	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)
		O.C.M.E. April 13, 2008
		20 News and address of parent who completed cause of death (Item 23a)
Ø		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
P	nie.	
Regis	tate trar	ADD 0 0 2008 k
		ODIOWAL

**Physician** /Medical **Examiner** be executed Box 68760, P.0. Division or Vital Records. To the Hospital or Attend within 24 hours after death To the Funeral Director:

Examiner physician and s the burial-trans attending p as signed by the a d be detached for page 2 should has certificate After this funeral Certification: the

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

iral", or Items 23a or 28a-f shov Examiner must be notifled at

"natural"

is marked other than "natural raumatic event, the Medical

Important: If its any Injury or o once.

death with

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.

Director

Funeral

Completed by

Be

ပ

Physician/Medical þ Completed Be 2

25. Was case referred to medical examiner? 2 No 1 Tyes 27. Manner of Death

29a. Certifier

1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete 31. Date filed (Month, Day, APR 22

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 1322 Alvin M. Shayt М 04-17-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) 09-19-1925 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 82 Maryland Director 218-14-7756 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 📉 No Director Maryland Harford Be1camp 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1208 Brice Square 21017 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2**X** No 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Editor Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Shayt Bessie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. Geraldine Shayt (Wife) 1208 Brice Square Belcamp, MD 21017 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04-18-2008 Baltimore, Maryland 21. Signature of Funeral Service Licenset 22. Name and Address of Facility 610 W MacPhail Rd Gchimunek Funcial inc MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Rass **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 7 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation

Showt Alvin (1 Kcoan 5505) Division or Vital Records, P.O. Box 68760,

burial-transit and attending physician been signed by the should be detached has been s ge 2 should page certificate After this funeral

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Hygiene.

Health and Mental

pe

within 24 hours after occ...
To the Funeral Director: Aft

8

Medical

State Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Bel

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Upper Chesapeake

31. Date filed (Month, Day, Year) 2 2 2008 APR

6 ☐ Could not be

3 ☐ Suicide 4 Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1.20 AM APRIL 2008 ANTONI JULIAN STACHOW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL DURTHAIH 201 WESTMINSTER ROAD If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex **Funeral** 1 M 2 ☐ F 90 061-28-7831 POLAND Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Wes 2 No MD WESTMINSTER Funeral Director CARROLL 10g. Citizen of What Country? 10e. Street and Number 2115 102 HIGHLAND ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: WHITE Be Completed by 3 ₩Widowed 4 Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) FLECTRICAL ASSEMBLER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) thent of Health and Mental Hydrach: If item 27 is marked out ころべてのそう 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FINVSBURL, MD 21049 POOLE ROAD. JUDY LANAHAN/DAUGHTER IN L 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GEALYSIAM, SEICHAM ANATOMY GIFTS TUELISTRY APRILDIDOUS 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Loensee 22. Name and Address of Facility

DNATOMY GIFTS PEGISTRY JEDD CONSIDER DRIVE STEP HANDLER MS DIOTE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eshu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF

ORUSHIEF funeral director, Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated.

State Registrar

X

31. Date filed (Month, Day, Year) APR 2 2 2008

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAI

29c. License number

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 Gertrude 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Levindale Geriatric Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F MARYLAND 056-12-6990 Director 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene "natural", or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1**X**Yes 2 ☐ No Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 21216 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: BLACK Baltimore, Maryland 21215-0036 Specify. <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) TAILOR CLEANERS 1214 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. WAZNWRIGH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PERCY E. SHANDS BALTO., Health tem 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWENES MELLS, MD. 21. Signature of Funeral Service Licensee BALTO, MD. 01223 2700 Edmondson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage /Medical Due to (or as a consequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit and Due to (or as a consequence of) attending physician P.O. Box 68760, pe IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ь 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

10

State

Belvedere Avenue, Baltimore, MD

2434

31. Date filed (Month, Day, Year)

WEST

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMIN TIEWS performed by Advisor State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death (If not institution. Examiner TIR (In yrs. It If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign last birthday **Funeral** Months Davs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show direct and extension of the control of the 1 Yes 2 □ No Completed by Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Marital Status Black, White, etc. within 72 hours after 1. ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical marked other than Elementary/Secondary (0-12) College (1-4or 5+) ear. 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental Hy item 27 Is marked 17. Father's Name (First, Middle, Last) Be DENC 19a. Informant's Name/Relationship (Type. Print Profile) nd Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street ar 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Discosition permit. Pages 1 Department of H Important: If ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State emete 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 □ Yes 2 □ No ate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 NO Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt.-VA 10 North Greene Street Baltimore, MD 21201 Nada Kiwan 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2 2 2008